Supplemental Questions Vermont Long-Term Care Plan Responses from Vermont March 16, 2003

Additional Funding Questions

In your response to the Request for Additional Information, you described the State's taxes on nursing facility and home health providers. Both are permissible, taxable classes of health care services. However, CMS would appreciate further detail about the taxes.

In general, in order to avoid triggering penalties under section 1903(w) of the Social Security Act, provider taxes must be:

- imposed on a permissible class of health care items or services defined in statue or regulation;
- imposed on all providers of the assessed health care service (broad-based);
- imposed at the same rate for all providers of the assessed service (uniformity); and,
- not hold any taxpayer harmless for the tax payment.

Based on the limited information provided; however, we cannot tell if these taxes are imposed in a broad based or uniform manner. Moreover, since we are not sure of the mechanisms that are funded by the tax receipts, we cannot tell whether or not the taxes meet the hold harmless provision. Please respond to the following questions:

1. Are all nursing facilities and home health providers assessed a provider tax? If not, what providers are excluded from the tax?

Yes, all nursing facilities and home health providers are assessed a provider tax.

2. What is the tax base? and 3. What are the tax rates for nursing facilities and home health organizations?

The nursing home tax is currently \$3,388.25 per bed per year. The home health tax is 16.0 percent of an agency's net operating revenues from core home health care services, excluding Medicare revenues.

4. How are the tax receipts used?

The tax receipts are paid into the Health Care Trust Fund, which is used to fund the state's share of the Medicaid program.

Of these funds the following special designated uses are specified out of the nursing home tax \$200.00 per bed is used for home- and community-based Medicaid waiver services and the net revenues generated by \$1,768.69 per bed (less the total amount of the state share of the inflation factor adjustments for state fiscal year 2002) is used to fund the nursing home wage supplement. This supplement is paid based on each facility's wage and benefit as a proportion of the total wage and benefit costs in 1997. The supplement will continue until the next nursing home cost rebase which will not be later than January 2005. If a home does not spend all the wage supplement

payments on increases on wages and benefit, the overpayments will be recouped at the time of the rebase.

None of the other tax revenues are specifically allocated to pay for particular programs.

5. Please submit a copy of the legislation enacting the tax.

The legislative language appears below: 33 VSA §1945, 1955a, and 1956.

- § 1954. Nursing home assessment
- (a) Beginning July 1, 2003, each nursing home's annual assessment shall be \$3,388.25 per bed licensed pursuant to section 7105 of this title on June 30 of the immediately preceding fiscal year. From the beginning of state fiscal year 2000, the annual assessment for each bed licensed as of the beginning of the fiscal year shall be prorated for the number of days during which the bed was actually licensed and any overpayment shall be refunded to the facility. To receive the refund, a facility shall notify the commissioner, in writing, of the size of the decrease in the number of its licensed beds and dates on which the beds ceased to be licensed.
- (b) The department shall provide written notification of the assessment amount to each nursing home. The assessment amount determined shall be considered final unless the home requests a reconsideration. Requests for reconsideration shall be subject to the provisions of section 1958 of this title.
- (c) Each nursing home shall submit its assessment to the department according to a schedule adopted by the commissioner. The commissioner may permit variations in the schedule of payment as deemed necessary.
- (d) Any nursing home that fails to make a payment to the department on or before the specified schedule, or under any schedule of delayed payments established by the commissioner, shall be assessed not more than \$1,000.00. The commissioner shall waive this late-payment assessment provided for in this subsection for good cause shown by the nursing home. (Added 1991, No. 94, § 1; amended 1991, No. 253 (Adj. Sess.), § 4; 1993, No. 56, § 1, eff. June 3, 1993; 1995, No. 5, § 27, eff. March 9, 1995; No. 14, § 3, eff. April 12, 1995; 1999, No. 49, § 202; 2001, No. 65, § 14; 2001, No. 142 (Adj. Sess.), § 120a; No. 143 (Adj. Sess.), § 49, eff. June 21, 2002; 2003, No. 66, § 307.)
- § 1955a. Home health agency assessment
- (a) Beginning July 1, 2003, each home health agency's assessment shall be 16.0 percent of its net operating revenues from core home health care services, excluding revenues for services provided under Title XVIII of the federal Social Security Act. The amount of the tax shall be determined by the commissioner based on the home

health agency's most recent audited financial statements, a copy of which shall be provided on or before December 1 of each year to the office of Vermont health access.

- (b) Each home health agency shall be notified in writing by the department of the assessment made pursuant to this section. If no home health agency submits a request for reconsideration under section 1958 of this title, the assessment shall be considered final.
- (c) Each home health agency shall submit its assessment to the department according to a payment schedule adopted by the commissioner. Variations in payment schedules shall be permitted as deemed necessary by the commissioner.
- (d) Any home health agency that fails to make a payment to the department on or before the specified schedule, or under any schedule for delayed payments established by the commissioner, shall be assessed not more than \$1,000.00. The commissioner shall waive this late payment assessment provided for in this subsection for good cause shown by the home health agency. (Added 1999, No. 49, § 203; amended 2001, No. 65, § 15; 2003, No. 66, § 309.)

§ 1956. Health care trust fund

- (a) The health care trust fund is hereby established in the state treasury. All assessments, including late-payment assessments, from health care providers under this subchapter shall be deposited in the fund. The proceeds of other taxes designated by law and donations may also be deposited in the fund. Interest earned on the fund and any remaining balance shall be retained in the fund for the purposes of this subchapter. The department shall maintain records showing the amount of money in the fund at any time.
- (b) All monies received from or generated to the fund shall be used for the state portion of Medicaid expenditures and for administration of provisions of this subchapter under subsection 1952(c) of this title. Of the net revenues generated by the \$3,388.25 per bed annual assessment on nursing homes, the net revenues generated by \$200.00 per bed shall be used for home- and community-based Medicaid waiver services and the net revenues generated by \$1,768.69 per bed, less the total amount of the state share of the inflation factor adjustments for state fiscal year 2002, as calculated by the division of rate setting pursuant to subsection 905(c) of this title, shall be used solely for Medicaid nursing home reimbursement as follows:
- (1) Beginning on July 1, 1999, until such time as all cost categories have been rebased pursuant to section 905(c) of this title on a base year no earlier than 2002, wage supplements shall be paid on a schedule to be determined by the commissioner. Such supplements shall be based on the change in expenditures incurred on or after

- January 1, 1999, as determined by the division of rate setting, for wages, salaries and fringe benefits incurred by nursing homes for direct care staff and for other employee groups in nursing homes, other than owners and administrators (net expenditures). The division of rate setting shall annually calculate the net expenditures for each nursing home. Notwithstanding subsection 905(c) of this title or any other provision of law, the change of base year for any component of the nursing home payment rate shall not be made later than January 1, 2005.
- (2) The wage supplement shall not be subject to any payment limitations imposed pursuant to section 907 of this title. The aggregate amount of the wage supplements paid to all nursing homes during any fiscal year shall not exceed the net revenues from the nursing home assessments set aside for that purpose for that year plus the federal matching funds for those net revenues. The annual wage supplement payment for a nursing home shall be its proportional share of the net revenues, based on the ratio of its nursing wages, salaries and fringe benefits paid by the nursing home for direct care staff and for other employee groups, other than owners and administrators, to the total for all nursing homes participating in the Vermont Medicaid program in the 1997 cost reports.
- (3) After all cost categories have been rebased, wage supplements shall cease. To the extent that total net expenditures by a nursing home are less than the total wage supplement payments to that home, the excess shall be deemed an overpayment and shall be recouped from the home on a schedule to be determined by the commissioner and deposited in the health care trust fund.
- (4) No wage supplement payments shall be made until such time as the lawsuit filed by nursing homes against the state of Vermont now pending in Washington superior court is dismissed with prejudice.
- (c) On or before January 1, 2000, the commissioner shall report to the general assembly on the operation of the health care trust fund and wage supplements.
- (d) No provision of this subchapter shall permit the state to reduce the level of state funds expended on the nursing home Medicaid program in any fiscal year below the level expended in fiscal year 1991 from the general fund for the nursing home Medicaid program.
- (e) The general assembly shall appropriate funds from the health care trust fund to the department of prevention, assistance, transition, and health access, the department of aging and disabilities, and the department of developmental and mental health services, and such funds shall be transferred to the departments' Medicaid and administrative appropriations as requested by the departments to carry out the purposes of this subchapter.

Eligibility Questions:

Your proposal will have an impact on several aspects related to financial eligibility. Some issues were discussed on the January 28th conference call and you agreed to provide greater detail, perhaps in chart form. Answers to the following questions will provide the detail we need to better understand the eligibility changes your propose:

6. Please provide a comparison (in chart or table form to assist us with our review) of current Medicaid state plan or 1915(c) eligibility criteria for each aged, blind or disabled group qualifying for mandatory or optional services. This will include mandatory categorically needy, optional categorically needy, and medically needy groups currently covered, and will indicate financial eligibility rules (income and asset limits, exclusions and disregards, including any more liberal methodologies under 1902(r)(2) of the Act). This information will be compared with the rules that will pertain to these groups under the proposed 1115 waiver so that it will be clear what the changes to eligibility will be. Please describe any income or resource disregards or special income levels that will be permitted for sub-sets of groups (e.g. a special income level for "moderate needs" individuals).

A comparison of eligibility criteria for all SSI-related Medicaid coverage groups is reflected in the chart, attached as Attachment 6. It specifies each aged, blind and disabled coverage group qualifying for the mandatory or optional services summarized in the chart, attached as Attachment 1. All categorically needy groups, optionally categorically needy groups, and the medically needy group are listed. It indicates the income and asset limits and methodologies applicable to each group. Exclusions and disregards from income and resources are specified in Vermont Medicaid Rules M232-M232.98, and M242-M242.2, attached as Attachment 2.

Financial eligibility for the Highest and High Needs Groups will mirror Vermont's current Long Term Care (Institutional) rules, except that under this demonstration we propose an initial resource exclusion for unmarried homeowners in the amount of \$3,000 and plan to increase that amount to \$7,000 as soon as we have sufficient data to determine the impact of that exclusion. Financial eligibility rules for the Moderate Needs Group have not yet been finalized. We are exploring the feasibility of modifying an existing process whereby providers determine financial eligibility using a unified income and resource standard of 300% of SSI. It will be similar to the methodology shown on Attachment 5. The information will be collected by providers and self-declared by participants.

7. Please clarify the State's proposed policies for co-payments, co-insurance, premiums, or any other required contributions or "patient share of cost" to be applied toward the cost of care. Explain the sliding income scale you intend to implement and show the amounts that will be expected to be contributed at various income levels, and describe the requirements that will pertain to continued provision of services to individuals who are unable to pay the expected amounts.

Vermont is not proposing any changes to the current methodology for calculating "patient share" contributions for individuals enrolled in the Highest or High Need groups. For these two groups, we will use the current method of calculating patient share for Long-Term Care Medicaid.

Individuals with resources in excess of \$10,000 but whose unified apportionment doesn't result in >300% SSI/month will be charged a participant share based on a uniform sliding fee scale.

8. Please describe any proposed future restrictions on the provision of current State Plan or waiver services for individuals who meet Medicaid financial eligibility criteria.

We do not propose any new restrictions on the provision of current State Plan or waiver services for individual who meet Medicaid financial eligibility criteria. We do not intend to make any changes for traditional Medicaid eligibles. We do plan to develop ways to better manage those services, with the goal of ensuring that the individual receives the right service in the right amount – no more and no less.

9. Please indicate the State's current and proposed methodology for post-eligibility treatment of income and illustrate how post-eligibility budgeting will be applied both for nursing home residents and those receiving community-based care under the waiver proposal. (If there is no change from current methodology, please summarize current methodology).

Post-eligibility treatment of income for long-term care, including waiver services, is currently applied as specified in Vermont Medicaid Rules M430-433, attached as Attachment 3. Under the proposed 1115 waiver these rules will be applied only to the Highest and High Needs groups.

10. Please describe how transfers of assets rules are currently applied and how they will be applied under the proposed waiver.

Transfer of asset rules for long-term care, including waiver services, are currently applied as specified in Vermont Medicaid Rules M440-M440.44, attached as Attachment 4. Under the proposed 1115 waiver these rules will be applied only to the Highest and High Needs groups.

11. We would like to explore your intentions about "grandfathering" and maintaining service options once care is initiated for individuals. Would you be willing to indefinitely grandfather individual's current service (pre-demonstration) options providing their conditions do not improve and their financial eligibility is maintained?

YES, that has always been our intention.

Similarly if service options change due to funding changes, as services are managed to available funds, would you be willing to continue service options once care is initiated?

We are concerned about discontinuing medically necessary care that is being provided to prevent deterioration and/or institutionalization and would like to be sure we understand your intentions and reasoning.

If service options change due to funding changes, individuals who are grandfathered in will be treated the same as all other enrollees. Any changes in the benefit package would affect all enrollees, as is the case today when services are reduced or eliminated. We will continue medically necessary services.

Specifically, we have the following questions that might help in providing needed details:

• You have indicated that once an individual is enrolled in any group, services will be maintained as long as the individual remains eligible. Will the re-assessments for individuals "grandfathered" into the demonstration be based on current eligibility criteria or the demonstration's eligibility criteria (i.e., are individuals grandfathered indefinitely or only until the next assessment)?

The reassessments for individuals who have been "grandfathered" into the demonstration will be based on the demonstration's eligibility criteria. As long as individuals meet the eligibility criteria for the Highest or High Need groups, they will continue to receive services in the setting of their choice—either nursing facility or home-and community-based settings. Individuals who upon reassessment move from the Highest Need to the High Need group will continue to receive their care in the setting of their choice—nursing facility or home and community-based care.

The menu of service options for the Highest and the High Need group is identical: case management; personal care; adult day; respite; companion services; assistive technology and home modifications; personal emergency response systems; Enhanced Residential Care; or nursing facility care. The type and amount of service is dependent on the assessed strengths and needs of the individual. If the assessment shows a change in need, then the care plan would be updated to reflect that change, e.g. the amount of personal care might increase or decrease or more adult day hours might be needed.

The menu for the Moderate Group will consist of case management, adult day services and/or homemaker services.

If the availability of funding changes, those individuals who have been "grandfathered" into the demonstration will continue to receive services in the amount identified in their assessments as long as they remain clinically eligible for either the Highest or High Need groups.

• Would these individuals maintain their current service options if their level of care (using existing criteria) remains the same or increases?

YES – see answer above.

Would these individuals maintain their current service options if the availability of funding changes?

YES – see answer above.

12. You have expressed your goal of initiating services to individuals as soon as possible employing presumptive eligibility to facilitate this goal. Before CMS can advise you, we will need to know more detail about the scope of your plans. That is, do you expect the State to bear the risk for payment of services if an individual is enrolled and later found ineligible? In what settings are individuals expected to be eligible, i.e., individuals being discharged from the hospital to community-based services; individuals in a nursing facility transitioning to the community; or individuals in the community enrolling in community-based services.

We would like to use the concept of presumptive eligibility to accomplish our goal of initiating services to individuals as soon as possible. The State is interested in sharing the risk with CMS for up to 45 days, for payment of services if an individual is enrolled and later found to be ineligible. We believe our methodology will create a situation where the risk to both the State and Federal government is minimal. Our State regional staff will be highly trained in many areas, including the criteria for financial eligibility. If they determine that the individual's financial situation is so clear and transparent that there can be no question about their eligibility, they will have the authority to authorize services to begin as soon as possible. For those individuals whose financial situation is not crystal clear, the usual process will be used to determine Medicaid long-term care financial eligibility.

Examples of cases that would fall into the "clear and transparent" category would be those individuals who: (1) are SSI recipients (2) have been on Community Medicaid for at least three years; (3) are well known to the local Area Agency on Aging case managers; (4) have been receiving Adult Day Services; or (5) are well known to the Department of Prevention, Assistance Transition and Health Access (PATH).

Enrollees will sign an agreement with providers acknowledging that they are responsible for paying for services delivered if they are found to be ineligible. The majority of home health agencies already use these agreements. The State would pay for services in those instances, only after the provider has shown evidence of a good faith effort to collect the debt and has been unable to do so.

Our State regional staff will see individuals in the hospital (on request), nursing facilities and in the community. Individuals being assessed and offered options in any of these settings could benefit from our "presumptive eligibility" methodology.

A question was raised in our 3/12/04 phone call with the Federal Review team concerning Vermont's current practices using presumptive eligibility. Vermont currently does not do presumptive eligibility determinations for children or pregnant women.

Benefits

- 13. Your proposal indicates that the State is confident that funds will be available to fully meet the Home and Community-Based Services needs of participants in the High Need group. In the event that funds would not be sufficient to serve the HCBS needs of this group, please confirm that participants in the High Need group would receive State Plan benefits.
- Please describe the State Plan benefits, particularly the long-term care benefits, the High Need group would receive if demonstration funds were not available, i.e. personal care, home health care.

Under the proposed 1115 waiver, individuals currently receiving long-term care services (the grandfathered group) will remain eligible for all acute care and long-term care services, provided they continue to meet the clinical and financial criteria that were in place when they began coverage (before the 1115 waiver). Individuals newly determined clinically eligible for the High Needs group and awaiting enrollment based on available funding, will receive State Plan or pharmacy-only benefits if they are otherwise eligible as is true today for individuals waiting for a 1915(c) Waiver slot to become available. Examples of State Plan services are nursing, LNA, physical therapy, speech therapy, occupational therapy, Assistive Community Care Services (ACCS) and Day Health Rehabilitative Services (DHRS).

• Please describe the State's experience with utilization review and control under the HCBS 1915(c) waiver program, the Vermont Health Access Plan, and under the State Plan. Please consider utilization and control procedures in lieu of managing services to available funding.

We do not intend to manage <u>services</u> to the available funding, but rather to manage the funding by adjusting the number of new enrollees. In other words, if funding becomes tight, some people might have to wait to become enrolled in the High Need group (Highest Need is our entitlement group and would not wait for services); however, we would not want to decrease services to existing enrollees as a management tool.

The following paragraphs describe our current utilization and control procedures under the Vermont Health Access Plan, under the State Plan and under the HCBS 1915(c) Waivers.

The Department of Prevention, Assistance, Transition and Health Access's Office of Vermont Health Access (OVHA) has years of experience in concurrent review, retrospective review and prior authorization processes to manage services provided to beneficiaries under both the Vermont Health Access Plan and the State Plan. We accomplish these tasks using both clinical staff at the Office of Vermont Health Access, clinical staff in other Departments within the Agency of Human Services as well as through assistance from contracted Peer Review Organization staff. We have developed and are implementing in April 2004 a Global Clinical Record, GCR, as an

enhancement to our Medicaid Management Information System within the Office of Vermont Health Access. This will improve our utilization review capability and complement the existing work of our staff and contracted staff. Specifically the Global Clinical Record has four components, Early Periodic Screening Diagnosis and Treatment notification, Case Tracking, Prior Authorization and Health Indicators. All of these components of the GCR will improve OVHA's ability to manage the care of Medicaid beneficiaries in Vermont.

(HCBS 1915(c) Waiver utilization review and control experience) The Department of Aging and Disabilities has extensive direct experience in performing utilization review and control under its current HCBS 1915(c) waiver programs. The Department has performed prospective review of 100% of all plans of care since the inception of the waivers. We have developed a very detailed assessment instrument, which is related directly to service utilization review and control, and we believe that we have effectively managed services to meet the needs of waiver participants. We have used a variant of this instrument in managing a state-funded personal care program, in which we have also performed prospective review and utilization control for more than twenty years. Our extensive experience, in which we ensure that the individual receives the needed services in the correct amount – no more, no less- has allowed us to provide these services within the available funding for the waiver program. We believe that our outcomes - high levels of participant satisfaction and a significant reduction in use of nursing home beds- confirm that our approach is both effective and appropriate. We will continue to use both utilization review and control as part of our operating procedures along with managing the available funding.

We will also work with CMS to find a mutually agreeable method for obtaining CMS input and approval if we find it necessary to change the menu of services.

14. Your response states that some High Need recipients will continue to be served in a Nursing Facility if that is their preference (Question 12 B, p 14). Does this pertain to new participants or just individuals who are grandfathered into the demonstration and are currently receiving services in a nursing facility? In the budget neutrality assumptions, you have indicated that 10 percent of participants in the High Need group (from 30 to 38 participants per year) may choose nursing facility services. That is, individuals will receive nursing facility services without meeting the new level of care criteria. What criteria will be used within the High Need group to determine who may have the choice of nursing facility or community-based care? From information provided on the January conference call, it is our understanding that a waiting list for nursing facility services will be created within the High Need group. At what point do funds become available for participants qualifying for the High Need group who choose nursing facility services?

Individuals who are grandfathered into the demonstration and are in the High Need group may elect to receive their long-term care in a nursing facility or home-and community-based setting. As new individuals are found eligible for the High Need group, they will be enrolled in the demonstration provided funds are available to

serve them. Assuming funds are available, if an individual prefers to receive his/her care in a nursing facility, that choice will be supported. Likewise, if the choice is for a home or community-based setting, that choice will be supported.

Under this demonstration, eligibility will be determined for long term care, which will be available in a variety of settings. Individuals will be eligible for one of three groups — Highest, High or Moderate Need. Those individuals who meet the criteria for the Highest Need group will be "entitled" to services, either in a nursing facility or in a home- or community-based setting. Those individuals who meet the criteria for the High Need group are not "entitled" to receive services, but will do so assuming funds are available. They then may choose their care setting after assessment and options counseling. We do not intend to use any criteria for the High Need group as far as determining who may have the choice of nursing facility or home-and community-based settings. Following the preliminary assessment and options counseling, that choice will be made by the individual (and family if appropriate).

If, at any point in time, there is a waiting list for the High Need group, the State regional staff will work with the local Waiver Teams, using a prioritization methodology that will be developed, to determine who will receive services next from the waiting list. We will consider clinical/medical and risk factors, using the five years of experience with our current prioritization methodology under the 1915(c) Waiver. We want to ensure that the Waiver Team does not consider the cost of the setting, but rather the care needs and expressed choice of the individual.

15. Section 1919(a)(1) of the Social Security Act defines the level of care for the nursing facility benefit. Three target groups are defined, for recipients who require (A) skilled care, (B) rehabilitation, and (C) care and services that were formerly known as intermediate care. Your proposal appears to restrict the nursing facility benefit to individuals who require the skilled nursing care and related services described in subparagraph (A). In fact, the proposed level of care definition appears to limit the nursing facility benefit to a subset of those individuals defined in 1919(a)(1)(A). We recognize that tightening the criteria for institutional care is at the core of your proposal. However, several potential difficulties arise.

The authority for providing the institutional class of services in your proposal must be constructed under Section 1115 authority since the benefit under which payment will be made in this proposal cannot be the nursing facility benefit. The nursing facility benefit may not be restricted in this manner. The intent of Congress in OBRA '87 was clearly to combine the Intermediate Care Facility and Skilled Nursing Facility level of care into a single benefit. Nursing facilities, as defined by 1919, must provide all three types of care.

The consequences of setting level of care criteria that are more restrictive than the Medicare skilled nursing facility benefit are complex. The affect on participants eligible for Medicare and Medicaid would need to be studied. Is it your intent to set nursing

facility level of care criteria in a manner that is not inclusive of individuals qualifying for the Medicare skilled nursing facility benefit?

We apologize if our Draft clinical eligibility criteria for the Highest and High Need groups are not clear. We are reviewing the layout and descriptions to discover where the apparent confusion lies. In addition we want to assure CMS that our criteria for the Highest Need group meets the relevant sections of the statute cited above. The definitions for key terms used in the criteria shown below are as follows:

TYPE OF ASSISTANCE	DESCRIPTION
Total Assistance	Full caregiver performance of the activity each
	time the activity occurred during the entire seven-
	day period. There is complete non-participation by
	the individual in all aspects of the ADL definition
	task.
Extensive Assistance	While the individual performed part of activity,
	weight-bearing support or full caregiver
	performance occurred 3 or more times over part
	(but not all) of the last seven days.
Limited assistance	Individual highly involved in activity, received
	physical help in guided maneuvering of limbs, or
	other <u>non-weight bearing</u> assistance <u>3 or more</u>
	times-OR-Limited assistance (3 or more times)
	<u>plus</u> extensive assistance provided only <u>1 or 2</u>
	times in the last 7 days.

For the Highest Need group, we believe we have ensured that those individuals in need of what was formerly known as "intermediate care" as well as those who need skilled nursing care are included. We are confident that the draft criteria for the Highest Need group includes individuals who are dually eligible for Medicare and Medicaid.

As described in our draft criteria for the Highest Need group, if an individual requires extensive or total assistance with one or more of the following "late loss" Activities of Daily Living (ADL; Toileting, Eating, Bed Mobility and Transferring; and at least limited assistance in any other ADL,

the individual is eligible for the Highest Need Group and you can stop here.

<u>OR</u>, if an individual has a severe impairment with decision making skills or a moderate impairment with decision making skills <u>and</u> one of the following behavioral symptoms/conditions that is not easily altered?

Wandering Physical abuse

Verbal Abuse Inappropriate Behavior

Resists Care

the individual is eligible for the Highest Need Group and you can stop here..

If neither one of those criteria make the individual eligible for the Highest Need group, then the assessor looks at the need for skilled care as follows:

Does the individual have any of the following conditions or treatments that require skilled nursing assessment, monitoring, and care on a daily basis?

Stage 3 or 4 Skin 2^{nd} or 3^{rd} DegreeVentilator/UlcersBurnsRespirator

IV Medications Parenteral Feedings Naso-gastric Tube

End Stage Disease Suctioning Feeding

If yes, individual is eligible for the highest need LTC Group and you can stop here.

If none of the criteria listed above makes the person eligible for the Highest Need group, then one more test is tried:

Does the individual have an unstable medical condition that requires skilled nursing assessment, monitoring and care on a daily basis related to conditions or treatments including but not limited to the following?

Dehydration Aspirations Cerebral Palsy

Internal Bleeding Chemotherapy Dialysis

Aphasia Quadriplegia Multiple Sclerosis
Transfusions Oxygen Respiratory Open Lesions
Vomiting Therapy Tracheostomy
Surgical Wounds Septicemia Radiation Therapy
Pneumonia Gastric Tube Feeding

If yes, individual is eligible for the Highest Need Group. If the individual did not qualify by means of any of the criteria above, then the assessor will determine if the individual is eligible for the High Need group.

We believe that by using the various tests described above, we have included individuals in both the former "intermediate care" group and the skilled care group.

The High Need clinical criteria identifies individuals who would appear in the following RUGs classifications: Reduced Physical Function A & B, Behavior Problems A & B, Clinically Complex A & B (if the need is less than daily). We anticipate conducting additional sample reviews to identify any unanticipated effect.

16. Individuals currently participating in Vermont's 1915(c) HCBS waiver program will be transitioning to the 1115 demonstration, if approved. Please explain your proposed process for transitioning participants to the new 1115 program including outreach efforts, information sharing, counseling and transition timeline.

At the start of the demonstration, all individuals who are participating in the 1915(c) Waiver will be automatically enrolled in the 1115 Waiver. At the time of their annual reassessment or reassessment as a result in a change in their condition or situation, the assessment data will be used to determine which of the three 1115 Waiver eligibility groups is correct from a clinical standpoint. Any necessary changes in plans of care will be submitted to the State regional staff for review and approval. The transition will be transparent to the beneficiaries. Information regarding choice of care setting will be provided at the time of the next assessment. We understand that the CMS Regional Office is researching any requirements for notice as it might pertain to both nursing home residents and 1915(c) Waiver participants and Vermont will provide legal notification as required.

Budget Neutrality

17. Your "with waiver" caseload projections for HCBS show strong growth over the course of the demonstration with nursing facility caseload increasing slightly. It appears you do not expect the new level of care to have an impact on "with waiver" HCBS growth for the Highest Need group. Actually, the percent of change in HCBS caseload in the "with waiver" projections (10.5 percent) is greater than the percent of change for the same group in the "without waiver" projections (9.8 percent). Please include your "with waiver" and "without waiver" assumptions for caseload trends for each Highest Need and High Need group, receiving community-based services.

The budget neutrality analysis assumes that under the "without waiver" scenario, there will be 1,625 HCBS enrollees in DY 1 (SFY 2005), and this caseload will continue to grow at the historical rate observed from 1999 - 2003. Under the "with waiver" scenario, the existing HCBS population will be split into Highest Need-HCBS and High Need-HCBS. For example, in 2005 there will be 1,355 Highest Need-HCBS enrollees and 270 High Need-HCBS enrollees, for a total of 1,625 (the remaining years are similarly bifurcated). When the line items are recombined, the trend rate for this group becomes identical under both scenarios.

The detailed assumptions underlying all trend rates can be found in Vermont's response to the initial set of CMS questions. It is important to note that overall trend rates will change once acute care costs have been added to the analysis.

18. As discussed in the January 28rd conference call, you indicated you will be providing revised budget neutrality information that includes all historic and projected Medicaid expenditures for the groups to be included in the demonstration. In the with- and without-waiver projections, please specify the amount of applied revenue. If approved, we will be developing a budget neutrality agreement based on a trend rate related to your historical expenditures (i.e., per diem cost net of applied revenue).

Participants will become a part of the 1115 demonstration and all expenditures would be considered as costs not otherwise matchable. That is, the State is at risk for all expenses, both long-term care and acute care. Since you are diverting individuals from higher cost

settings through early intervention there should be savings. Likewise, we want to be aware of the potential for increased costs in the community that could be related to the demonstration intervention.

Vermont will provide this information on or about March 22, 2004.

.Summary of Vermont Covered Services

Acute care - mandatory

- Physicians' services
- Laboratory and x-ray services
- Inpatient hospital services
- Outpatient hospital services, including those given at rural health clinics and federally-qualified health centers
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21
- Family planning services
- Nurse midwife services
- Certified nurse practitioner services

Acute care - optional

- Medical care or remedial care furnished by licensed practitioners under state law
- Prescribed drugs, dentures, prosthetic devices, eyeglasses (except no dentures or eyeglasses)
- Diagnostic, screening, preventive and rehabilitative services
- Clinic services
- Primary care case management services
- Dental services
- PACE services will be coming later in 2004
- Physical therapy and related services
- Other specified medical and remedial care

Long-term care - mandatory nursing facility services for individuals 21 or over

- a. Room and board
- b. Required nursing services (except private duty nurses)
- c. Therapy services (physical, occupational, inhalation, recreational, etc.)
- d. Modification of diet (i.e., salt free, low-fat, diabetic and other special diets)
- e. Other special care charges (hand feeding, incontinency, total care, etc.)
- f. Washing personal clothing and provision of clean bedding
- g. Bathroom supplies
- h. All over-the-counter medicines prescribed by the physician;
- i. Sterile water, saline solution, etc.;
- j. All medical supply items ordered by the physician;
- k. Use of durable medical equipment with whatever frequency is medically indicated.
- 1. Prescription drugs

Long-term care – optional services

Institutional Services

- Intermediate care facility for individuals with mental retardation (ICF/MR) services
- Inpatient psychiatric hospital services for individuals under age 21

Home & Community-Based Services

- Home health care services
- Case management services
- Personal care services (including Participant Directed Attendant Care services)
- Hospice care
- Enhanced residential care (nursing, 24 hour supervision, homemaker, assistance with medicine, etc.)
- Supported living arrangements services for the developmentally disabled
- Respite care
- Adult day care
- Assistive devices and modifications

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Vermont Department of Prevention,
Assistance, Transition, and Health Access

Medicaid Rules

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M232 Excluded Resources

This section specifies the resources whose value the department excludes in determining SSI-related Medicaid eligibility.

M232.1 Real Property

The department excludes the following real property as resources when determining Medicaid eligibility.

M232.11 A Home and Contiguous Land

The department excludes a person's home as a resource, regardless of its value. The department may consider it as a resource, however, when determining whether a long-term care applicant has transferred it and should be subject to a penalty period (M440).

Home means the property in which an individual resides and has an ownership interest and which serves as the individual's principal place of residence. This property includes the shelter in which an individual resides, the land on which the shelter is located, related outbuildings, and surrounding property not separated from the home by intervening property owned by others. Public rights of way, such as roads that run through the surrounding property and separate it from the home, will not affect the exemption of the property. The home includes contiguous land and any other buildings located on the land.

The home exclusion applies even if the owner is making an effort to sell the home. The home exclusion also applies if the owner is absent from the home due to institutionalization, provided that the owner has not placed the home in a revocable trust and:

- intends to return to the home even if the likelihood of return is apparently nil;
- has a spouse or dependent residing in the home; or
- has a medical condition that prevented the owner from living there before institutionalization.

Dependent means: child, stepchild, or grandchild; parent, stepparent, or grandparent; aunt, uncle, niece, or nephew; brother or sister, stepbrother or stepsister, half brother or half sister; cousin; or in-law.

Unless one of the exceptions listed above applies, the home becomes a countable resource when the owner moves out of the home without the intent to return, because it is no longer the owner's principal place of residence. Temporary absences, such as for hospitalization or convalescence with a relative, do not affect the determination of an individual's principal place of residence.

Vermont Department of Prevention,	
Assistance, Transition, and Health Access	

Medicaid Rules

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M232 <u>Excluded Resources</u> (Continued)

M232.12 Proceeds From the Sale of an Excluded Home

The department excludes proceeds from the sale of a home to the extent that the owner intends to use them and, in fact, uses or obligates them to purchase or construct another home within three months of the date the proceeds are received. Use of proceeds from the sale of a home to pay costs of another home will be excluded only if the other costs are paid within three months of the sale of the home. Such costs are limited to the down payment, settlement costs, loan processing fees and points, moving expenses, necessary repairs to or replacements of the new home's structure or fixtures (e.g., roof, furnace, plumbing, built-in appliances) identified and documented prior to occupancy, and mortgage payments for the new home.

The value of a promissory note or similar installment sales contract constitutes a "proceed." Other proceeds consist of the down payment and the portion of any installment amount constituting payment against the principal. These are also excluded if used within 3 months to make payment on the replacement home.

When all of the proceeds are not timely reinvested as specified above, the portion of the proceeds retained by the individual are combined with the value of the note or installment sales contract and counted as a resource beginning with the month following the month the note is executed. If the entire proceeds are fully reinvested in a replacement home at a later date, the value of the note and reinvested proceeds are excluded beginning with the month after the month in which they are reinvested, but any proceeds not reinvested as specified above remain a countable resource until fully reinvested.

M232 Excluded Resources (Continued)

M232.13 Real Property for Sale

The department excludes real property from countable resources as long as owners verify that they are making reasonable efforts to sell it. Reasonable efforts to sell property means taking all necessary steps to sell it for fair market value in the geographic area covered by the media serving the area in which property is located, unless owners are prevented by circumstances beyond their control from taking these steps.

The steps considered necessary to sell the property depend on the method of sale. Owners may choose to list the real property with a real estate agent or undertake to sell it themselves. If owners choose to list it with a real estate agency, they must take the necessary step of listing it and cooperating with the real estate agent's efforts to sell it. If owners choose to sell it without an agent, they must take all of the following necessary steps:

- advertise it in at least one of the appropriate local media continuously;
- place a "For Sale" sign on the property continuously, unless prohibited by zoning regulations;
- conduct open houses or otherwise show the property to prospective buyers; and
- attempt any other appropriate methods of sale.

If any prospective buyer makes a reasonable offer for the property, owners must accept it or demonstrate why it was not a reasonable offer. Any offer at least two-thirds of the most recent estimate of the property's fair market value is considered a reasonable offer.

Fair market value means a certified appraisal or an amount equal to the price of the property on the open market in the locality at the time of the transfer or contract for sale, if earlier.

M232.14 Home Equity Conversion Plans

(a) Definition

Home equity conversion plans are financial instruments used to secure loans with real property as collateral. Home equity conversion plans include reverse mortgages, reverse annuity mortgages, sale-leaseback arrangements, time-sale agreements, and deferred payment loans.

(b) Exclusion

The department excludes as a resource, in the month of receipt, funds from any home equity conversion arrangements on real estate.

M232 Excluded Resources (Continued)

M232.15 Jointly Owned Real Property

(a) General exclusion

The department will exclude jointly owned real property from countable resources as long as the joint owner refuses to sell, if the joint ownership was created:

- (i) before July 1, 2002; or
- (ii) more than 36 months before the date of application.

The department considers that the addition of new joint owners creates a new joint interest and will be evaluated as a countable resource under M233.23.

(b) Exclusion due to undue hardship

Jointly owned real property will be excluded from resources if sale of the property by an individual would cause the other owner undue hardship due to loss of housing. Undue hardship would result when:

- (i) the property serves as the principal place of residence for one (or more) of the other owners;
- (ii) sale of the property would result in loss of that residence, and
- (iii) no other housing would be readily available for the displaced other owner.

M232.16 Life Estates

(a) <u>Definition</u>

Life estate means a legal arrangement entitling the owners to possess, rent, and otherwise profit from real or personal property during their lifetime. The owner of a life estate sometimes may have the right to sell the life estate but does not normally have future rights to the property. Ownership of a life estate may be conditioned upon other circumstances, such as a new spouse. The document granting the life estate includes the conditions for the life estate and the right of the owner to sell or bequeath it, if these property rights were retained.

M232 Excluded Resources

M232.16 <u>Life Estates</u> (Continued)

(b) Exclusion for life estate interests created on or after July 1, 2002

When owners retain the power to sell the entire real property, including any remainder interest, the department excludes the value of the life estate in the real property only if the life estate is an interest in the individual's home (M232.11). For this purpose, the value of the life estate includes the value of the remainder interest.

The department excludes life estates in real property when the owner does not retain the power to sell the real property.

(c) Exclusion for life estate interests created before July 1, 2002

When owners retain the power to sell the entire real property, including any remainder interest, the department excludes the value of the life estate in the real property only if the life estate is excludable on another basis, such as because it is real property producing significant income (M232.17).

The department excludes life estates in real property when the owner does not retain the power to sell the real property.

M232.17 Real Property Producing Significant Income

Real property producing significant income is exempt from consideration as a resource. Real property is considered to produce "significant income" if it generates at least 6 percent of its fair market value in net annual income after allowable expenses related to producing the income are deducted.

Until July 1, 2003, determinations and redeterminations of eligibility for individuals who have received SSI-related or ANFC-related Medicaid at any time between July 1, 2001 and June 30, 2002, and have property producing significant income, shall have property producing significant income evaluated based on the rules in effect on June 30, 2002.

M232.18 Real Property Producing Goods For Home Consumption

Real property used to produce goods for only home consumption (e.g., a garden plot used to raise vegetables to be eaten at home or a wood lot used to provide fuel to heat the home) is exempt from consideration as a resource. When real property is used to produce goods for both home consumption and income production, the department excludes only the part used to produce goods for home consumption. The part of the property used for income production is evaluated for exclusion under rule M232.17.

M232 <u>Excluded Resources</u> (Continued)

M232.2 Life Insurance

(a) Definition

Life insurance is a contract that provides for its purchaser to pay premiums to the insurer, who agrees to pay a specific sum to a designated beneficiary upon the death of the insured. Life insurance is usually sold by an insurance company but may also be sold by other financial institutions, such as brokerage firms.

The face value of a life insurance policy is the amount it pays the beneficiary upon the death of the insured. Term life insurance is life insurance that does not accumulate any cash value through time as premiums are paid. Whole life insurance (sometimes called ordinary life, limited payment, or endowment insurance) accumulates value as premiums are paid. It may also pay periodic dividends on this value when all premiums have been paid. These dividends may be paid to the owner, or they may be added to the cash surrender value of the policy.

The cash surrender value (CSV) of a whole life policy represents the amount the owner would receive upon terminating the policy before the insured dies. It is a form of equity that accumulates over time as life insurance premiums are paid. The policy owner may borrow against the CSV according to the terms of the policy. A loan against a policy reduces its CSV.

A life insurance policy can be either a group or individual policy. Group policies are usually issued through a company or organization insuring the participating employees or members and perhaps their families. The group policy may be paid partially by the employer. Group insurance policies generally have no CSV.

(b) Exclusion

The value of a life insurance policy is excluded as a resource according to the following rules:

- (i) If the combined face value of the whole life insurance policies owned by any one member of the financial responsibility group does not exceed \$1500, their cash value may be excluded. If the total face value exceeds \$1500, their cash value, excluding any amounts up to \$1500, and all dividend additions are considered a countable resource.
- (ii) Regardless of its face value, term life insurance is not countable as a resource.

M232 Excluded Resources (Continued)

M232.3 Burial Funds

(a) Definition

A burial fund is any separately identifiable fund clearly designated as for burial expenses through the title to the fund or by a sworn statement provided to the department. Burial funds include contracts, trusts, or other agreements, accounts, or instruments with a cash value. Some burial funds include accumulated interest, and the value of some burial funds may change through time (e.g., when the fund consists of bonds). Burial expenses include burial spaces, items related to burial spaces, and services related to burial spaces.

The cash value of life insurance policies may also be treated as burial funds for the purposes of determining Medicaid eligibility if owned by an individual whose income and resources are considered in determining Medicaid eligibility and designated as specified above.

For the purposes of determining Medicaid eligibility, burial spaces, if not fully paid, are considered burial funds and include burial plots, gravesites, crypts, mausoleums, caskets, urns, and other repositories customarily and traditionally used for the deceased bodily remains. Items related to burial spaces include, but are not limited to, vaults, headstones, markers, plaques, and burial containers for caskets. Services related to burial include, but are not limited to, embalming, opening and closing of the gravesite, and care and maintenance of the gravesite, sometimes called an endowment or perpetual care.

(b) Exclusion

For any individual whose income and resources are considered in determining SSI-related Medicaid eligibility, the department excludes up to \$10,000 of burial funds, as long as the member shows that the funds are designated for burial expenses through the title to the fund or by a sworn statement provided to the department. They must be separately identifiable and not commingled with other funds.

A burial fund may be excluded as of the first day of the month in which the individual whose income and resources are considered in determining Medicaid eligibility established it. Interest and appreciation accrued on burial funds is excluded if the funds have been left to accumulate.

The value of certain burial spaces may also be excluded under the allowable limit of \$10,000 for each individual whose income and resources are considered in determining Medicaid eligibility. Such spaces must be held for the burial of a member of the applicant's immediate family. For this purpose, the immediate family includes the member's spouse, children, brothers, sisters, and parents.

Irrevocable burial trusts established prior to July 1, 2002 and funded in excess of \$10,000 shall be excluded up to the value of the trust as of June 30, 2002.

M232 Excluded Resources (Continued)

M232.4 Annuities

(a) Definition

For Medicaid purposes, an annuity is a contract reflecting payment to an insurance company, bank, charitable organization, or other registered or licensed entity.

(i) Parties to an annuity

There are always two parties to an annuity: the writer of the annuity, usually an insurance carrier or charitable organization, and the purchaser who owns the annuity.

In addition to the formal parties to an annuity, annuities also name a beneficiary: the person who will be paid a regular stream of income from the annuity in equal payments. Anyone can be a beneficiary, including but not limited to, the owner of the annuity, a spouse, dependent, trust, estate, commercial entity, proprietorship, or charitable organization.

Beneficiaries may be revocable or irrevocable. A revocable beneficiary can be changed by the owner of the annuity at any time. An irrevocable beneficiary can be changed only by the written permission of that beneficiary.

In addition to the primary beneficiary, annuities can provide for a contingent beneficiary or residual beneficiary. A contingent or residual beneficiary will receive annuity payments upon the occurrence of a specified condition.

(ii) Types of annuities

There are many types of annuities. For Medicaid purposes, the department considers whether annuities of any type are available as a liquid resource. Since annuities are trust-like instruments, the department uses terminology similar to trusts, when it describes the availability of cash from annuities.

Annuities that name revocable beneficiaries are available because they can be surrendered, cashed in, assigned, transferred, or allow the beneficiary to be changed. The department presumes revocability when an annuity contract is silent regarding revocability.

Annuities are unavailable when the owner of an annuity is not the Medicaid applicant or applicant's spouse or the applicant or spouse has abandoned all rights of ownership.

M232 Excluded Resources

M232.4 <u>Annuities</u> (Continued)

(iii) Standard annuity contract provisions

There are two phases to an annuity: an accumulation phase and a payout phase. Annuities vary in how they accumulate and payout money. Annuities may accumulate money by payment of a single lump sum or by payments on a schedule, which accumulate interest over time. Once an annuity has matured, money is paid to the beneficiary according to the terms of the annuity contract.

Annuity contracts provide for payments over a certain period. For the purposes of Medicaid eligibility, the payout period of an annuity must equal the life expectancy of the person on whose life the annuity is based or else it will be counted as a resource or considered a transfer of assets at less than fair market value. The department determines life expectancy based on the tables in §3258.9 of the State Medicaid Manual published by the federal Centers for Medicare and Medicaid Services, and referenced in the department's Medicaid procedures manual.

(b) Exclusion

The department excludes annuities if they were purchased more than 36 months ago, or if they:

- (i) have no beneficiary other than an individual requesting long-term care Medicaid or his or her spouse; and
- (ii) provide for payments to applicants or their spouses in equal intervals and equal amounts;
- (iii) are based on the actuarial life expectancy of the applicants or their spouses, as determined by the department; and
- (iv) return to the beneficiary at least the amount used to establish the annuity and any additional payments plus any earnings, as specified in the annuity contract; and
- (v) do not pay anyone other than the applicant or the applicant's spouse, even if the applicant or spouse dies before the payout period ends.

Once eligibility has been determined, if someone other than the long-term care recipient or spouse becomes a beneficiary of the annuity, the recipient shall be precluded from allocating income to the community spouse up to the amount of the previously available annuity payment.

M232 Excluded Resources (Continued)

M232.5 Resources Managed by a Third Party

M232.51 Definition of Trust

A trust is a legal document setting forth the terms of any arrangement in which a person (the grantor) transfers liquid or nonliquid property (the trust principal) to another person or entity (the trustee) with the intention that it be held, managed, or administered by the trustee for the benefit of one or more individuals (the grantees). In some cases, the grantor is named as a grantee. The grantor may also be called the settlor or the trustor. The grantee may also be called the beneficiary.

Trust income refers to monies earned by the trust property. It may take various forms, such as interest, dividends, or rent payments. Trust income may also be called trust earnings. The trust principal plus the trust income make up the trust property.

A person shall be considered the grantor of a trust if both of these two conditions are met:

- (a) the assets of the person were used to form all or part of the principal of the trust; and
- (b) one of the following established the trust:
 - the person;
 - another person, court, or administrative body, with legal authority to act in place of or on behalf of the person; or
 - another person, court, or administrative body, acting at the direction of or upon the request of the person.

The trustee may be an individual or an entity, such as a bank or insurance company. In most cases, trustees do not have the legal right to use the trust property for their own benefit. Some, but not all, trusts grant discretion to the trustee to use judgment as to when or how to handle trust principal or trust income. A trust may provide reasonable compensation to the trustee for managing the trust as well as reimbursement for reasonable costs associated with managing the trust property.

A trust may name a person or entity, called the residual beneficiary, as the recipient of the trust property upon the death of the grantee.

M232 <u>Excluded Resources</u> (Continued)

M232.52 Excluded Trusts

In general, the department excludes trusts as a resource to individuals who cannot revoke the trust or receive trust property, whether or not the trustee exercises his or her full discretion. Trust property is also excluded as a resource when the grantor is a member of the financial responsibility group and established a testamentary trust, also known as establishing a trust by will.

The following trust property is excluded as a resource when either the grantor or the grantee is a member of the financial responsibility group:

- (a) trust property in a trust established prior to April 7, 1986, for the sole benefit of a mentally retarded person residing in an ICF-MR;
- (b) trust property in a trust for which the grantee is a disabled child under <u>Sullivan v. Zebley</u>, 493 U.S. 521 (1990);
- (c) trust property or any portion of the trust property that cannot be made available to the member of the financial responsibility group, either through full exercise of the trustee's discretion under the terms of the trust or through revocation of the trust by a member of the financial responsibility group;
- (d) trust property in a trust established by persons other than the individual or spouse are excluded unless the terms of the trust permit the individual to revoke the trust or to have access to it without trustee intervention:
- (e) irrevocable trusts, including homes placed in irrevocable trusts by institutionalized individuals who intend to return to them, from which no payment under any circumstances could be made to the individual; or
- (f) special or supplemental needs trusts or pooled trusts that meet the following requirements:
 - (i) The special or supplemental needs trust names a beneficiary under the age of 65 and meets all the criteria below in section M232.52(f)(iii).
 - (ii) The pooled trust was established and managed by a nonprofit association, a separate account is maintained for each beneficiary of the trust, and it meets all the criteria below in section M232.52(f)(iii).

M232 Excluded Resources

M232.52 <u>Excluded Trusts</u> (Continued)

- (iii) The special or supplemental needs trust or pooled trust:
 - (A) contains the assets of a disabled individual;
 - (B) was established by a parent, grandparent, or legal guardian of the individual or by a court;
 - (C) was established for the sole benefit of the beneficiary, which means that no individual or entity except the disabled beneficiary can benefit from the trust in any way, until after the death of the beneficiary and then not before the department receives sums owed under the payback provision; and
 - (D) includes a payback provision which requires that, upon the death of the beneficiary, any amounts remaining in the trust will first be paid to the department in an amount equal to the total Medicaid payments made on behalf of the individual.

In the case of a trust with more than one grantor, these exclusions apply only to that portion of the trust attributable to the income or resources of a member of the financial responsibility group. In the case of a trust with more than one grantee, the exclusions apply only to that portion of the trust available for the benefit of a member of the financial responsibility group.

M232 Excluded Resources (Continued)

M232.53 Trusts Excluded Due to Undue Hardship

The department may exclude trust property that has not been distributed if counting it as a resource would cause undue hardship to a grantor or grantee who is a member of the financial responsibility group.

Undue hardship includes situations in which a member of the financial responsibility group or someone in the member's immediate family would be forced to go without life-sustaining services because the trust property could not be made available to pay for the services. For this purpose, the immediate family includes the member's spouse, children, brothers, sisters, and parents.

The following situations also would cause undue hardship:

- (a) funds can be made available for medical care only if trust property is sold, and this property is the sole source of income for the member or someone in the member's immediate family; and
- (b) funds can be made available for medical care only if income-producing trust property is sold and, as a result of this sale, the member or someone in the member's immediate family would qualify for Supplemental Security Income, Reach Up, Aid for the Aged, Blind or Disabled, General Assistance, Food Stamps, or another public assistance program requiring a comparable showing of financial need.

Undue hardship does not exist when application of the trust regulations does not cause individuals risk of serious deprivation.

Individuals claiming undue hardship must submit a written request and any supporting documentation. Claims of undue hardship are forwarded to the commissioner's designee for evaluation. Required documentation from the individual can include but is not limited to the following:

- a statement from the attorney, if one was involved;
- verification of medical insurance coverage and statements from medical providers relative to usage not covered by the insurance; or
- a statement from the trustee.

When application of trust provisions are waived because they would cause the individual undue hardship, only amounts actually distributed from the trust and held for more than a month are counted as a resource. Request for consideration of undue hardship does not limit an individual's right to appeal denial of eligibility for any reason, including the determination of undue hardship.

M232 Excluded Resources (Continued)

M232.6 Early Withdrawal Penalties and Surrender Fees

The department excludes early withdrawal penalties and surrender fees assessed by the financial institution to the extent that they reduce the value of the liquidated proceeds. Examples of these resources are retirement funds, annuities, bonds, and certificates of deposit.

Income tax withholding and tax penalties for early withdrawal are not excluded.

M232.7 Jointly Held Accounts

The department will exclude a jointly held account only if the owner rebuts the presumption of availability by:

- (a) submitting a statement, along with corroborating statements from other account holders, regarding who owns the funds in the joint account, why there is a joint account, who has made deposits to and withdrawals from the account, and how withdrawals have been spent;
- (b) submitting account records showing deposits, withdrawals, and interest, if any, in the months for which ownership of funds is at issue; and
- (c) taking one of the following two actions:
 - correcting the account title to show that the member of the financial responsibility group is no longer a co-owner, if the member owns none of the funds; or
 - if the member owns only a portion of the funds, separating the funds owned by other account holders from the member's funds and correcting the account title on the member's funds to show they are solely owned by the member.

M232.71 Fiduciary for a Joint Fiduciary Account

(a) Definition

A joint fiduciary account is a deposit in a financial institution in the name of an owner naming one or more fiduciaries. The owner makes a clear statement about how the money can be used, and the fiduciary is required to follow those instructions and keep track of how the money is spent.

(b) Exclusion

When an individual owns such an account, it is counted as a resource. When an individual is designated a fiduciary, the joint fiduciary account is an excluded resource for the fiduciary.

M232 Excluded Resources (Continued)

M232.8 Other Excluded Resources

The department also excludes the following resources.

M232.81 Household Goods and Personal Effects

The department excludes home furnishings, apparel, personal effects, and household goods. This includes tools, equipment, uniforms and other nonliquid property required by an individual's employer or essential to self-support.

M232.82 Vehicles

The department excludes all automobiles. It also excludes other vehicles, such as trucks, boats, and snowmobiles, only if they are used to provide necessary transportation (i.e., an automobile is unavailable or cannot be used to transport the aged, blind or disabled individual).

M232.83 Cash Considered Income in the Month of Receipt

The department excludes income as a resource in the month of receipt, such as automatic deposit of a social security check into a checking account.

M232.84 Cash Necessary to Operate a Business

The department excludes cash necessary to operate a business, using a month's average expenditures as determined by tax returns, or business receipts and expenses for the past 12 months. No more than three times the average monthly cash expenditures can be excluded.

M232 <u>Excluded Resources</u> (Continued)

M232.85 Retirement Funds

(a) Definition

Retirement funds include any resources set aside by a member of the financial responsibility group to be used for self-support upon the withdrawal from active life, service, or business. Retirement funds include but are not limited to IRAs, Keogh plans, 401K plans, pensions, mutual funds, stocks, bonds, securities, money market accounts, whole life insurance, and annuities.

(b) Exclusion for community Medicaid

The department excludes retirement funds owned by the individual requesting Medicaid when both criteria are met.

- (i) The individual must resign from a job to receive retirement benefits from the funds or has applied for periodic retirement benefits in lieu of a lump-sum payment.
- (ii) If the individual has reached retirement age, the individual is drawing on retirement funds at a rate consistent with the life expectancy tables in the Medicaid procedures manual.

(c) Exclusion for long-term care

The department excludes retirement funds owned by a member of the financial responsibility group when both criteria are met.

- (i) The owner is not applying for or receiving Medicaid and either:
 - must resign from a job to receive retirement benefits from the funds; or
 - has applied for periodic retirement benefits in lieu of a lump-sum payment.
- (ii) If the member of the financial responsibility group with retirement funds has reached retirement age, the member is drawing on retirement funds at a rate consistent with the life expectancy tables in the Medicaid procedures manual.

M232.86 <u>Tax Refunds</u>

The department excludes tax refunds on real property, income, and food.

M232 Excluded Resources (Continued)

M232.87 Student Benefits

The department excludes any portion of any grant, scholarship, or fellowship used to pay fees, tuition, or other expenses necessary to securing an education. Portions used to defray costs of food, clothing, or shelter must be counted.

M232.88 Savings from Excluded Income

The department excludes savings from excluded income and resources. This includes but is not limited to the following:

- (a) liquid resources, including interest earned by the resources accumulated from earnings by a person working with disabilities (see M200.24(b) on or after January 1, 2000, and kept in a separate bank account from other liquid resources, unless no bank within a reasonable distance from residence or place of work permits the person working with disabilities to establish a separate account without charging fees; and
- (b) nonliquid resources purchased by a person working with disabilities on or after January 1, 2000, with savings from earnings or with a combination of savings from earnings and other excluded income or resources.

M232.89 Resources Excluded by Federal Law

The following are excluded by federal law from both income and resources:

- (a) The value of meals and food commodities distributed under the National School Lunch Act and the Child Nutrition Act.
- (b) The value of Food Stamps or Food Stamp cash-out checks.
- (c) The value of food or vouchers received through the WIC Program.
- (d) The value of food or meals received under the Older Americans Act.
- (e) Compensation or remuneration received for volunteer work in ACTION programs including foster grandparents, RSVP, SCORE, ACV, ACE, VISTA, Senior Companion Program and UYA.
- (f) The value of assistance received under the U.S. Housing Act, U.S. Housing Authorization Act and the Housing and Urban Development Act.
- (g) The value of relocation assistance to displaced persons under the Uniform Relocation and Real Property Acquisition Policies Act.
- (h) Per Capital distributions to certain Indian Tribes and receipts from lands held in trust for certain Indian Tribes.
- (i) Payments received under the Alaskan Native Claims Settlement Act.

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M232 <u>Excluded Resources</u>

M232.89 Resources Excluded by Federal Law (Continued)

- (j) Grants or loans received for educational purposes under any U.S. Department of Education program.
- (k) Any assistance received under the Emergency Energy Conservation or Energy Crisis Program.
- (l) Any assistance received under the Low-Income Home Energy Assistance Act, either in cash or through vendor payments.
- (m) Compensation paid to Americans of Japanese or Aleut ancestry as restitution for their incarceration during World War II.
- (n) Agent Orange Settlement payments.
- (o) German reparations to concentration camp survivors, slave laborers, partisans, and other victims of the Holocaust. Settlement payments to victims of Nazi persecution or their legal heirs resulting from the confiscation of assets during World War II.
- (p) War reparations paid under the Austrian government's pension system.
- (q) Radiation Exposure Compensation Trust Fund payments.
- (r) Assistance received under the Disaster Relief and Emergency Assistance Act or other assistance provided under a Federal statute because of a catastrophe which is declared to be a major disaster by the President of the United States. Comparable assistance received from a State or local government, or from a disaster assistance organization is excluded. Interest earned on the assistance is also excluded.
- (s) Netherlands' Act on Benefits for Victims of Persecution 1940-1945 payments.
- (t) Any account, including interest or other earnings on the account, established and maintained in accordance with section 1631(a)(2)(F) of the Social Security Act. These accounts are established with retroactive SSI payments made to a child under age 18 and used in ways specified in the Act. The exclusion continues after the child has reached age 18.
- (u) Earnings deposited in a special savings account under the Tangible Assets project managed by the Central Vermont Community Action Council and authorized by The Personal Responsibility and Work Opportunity Reconciliation Act of 1996.
- (v) Payments as the result of a settlement in the case of Susan Walker v. Bayer Corporation, et al. made to hemophiliacs who contracted the HIV virus from contaminated blood products.

M232.9 Resources Excluded for Limited Periods

The department excludes the following resources for specific periods, beginning with the date on which a member of the financial responsibility group received the resource.

M232.91 Retroactive Social Security and SSI/AABD Payments

The department excludes retroactive payments of federal SSI, the AABD supplement to SSI, or social security benefits for nine months beginning with the month after the month of receipt. These payments are also excluded as resources during the month of receipt.

M232 Excluded Resources (Continued)

M232.92 Funds for Replacing a Lost, Stolen, or Damaged Excluded Resource

The department excludes cash and interest earned on that cash received from any source, including casualty insurance, for the purpose of repairing or replacing an excluded resource that is lost, stolen, or damaged, if used to replace or repair that resource. The exclusion is allowed for nine months from the month of receipt. An extension of an additional nine months can be granted for good cause.

M232.93 Earned Income Tax Credit

The department excludes state and federal earned income tax credit refunds and advance payments from consideration as resources.

M232.94 Cash Payments for Medical or Social Services

The department excludes cash received for medical or social services for the calendar month following the month of receipt. The month following the month of receipt, the department counts it as a resource if it has been retained.

M232.95 Victim's Compensation Payments

The department excludes state-administered victims' compensation payments for nine months after the month of receipt.

M232.96 Relocation Payments

The department excludes state and local government relocation payments for nine months after the month of receipt.

M232.97 Funds for Expenses Resulting from Last Illness and Burial

The department excludes payments, gifts, and inheritances occasioned by the death of another person provided that they are spent on costs resulting from the last illness and burial of the deceased by the end of the calendar month following the month of receipt.

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M232 Excluded Resources (Continued)

M232.98 Stocks, Bonds, Mutual Funds, and Money Market Funds

(a) Definition

Legal instruments authenticating an investment, such as stocks, bonds, mutual funds, and money market funds pay interest at specified intervals, sometimes pay dividends, and are convertible into cash either on demand or at maturity.

(b) Exclusion

The department excludes U.S. savings bonds during their minimum retention period.

M242 <u>Income Exclusions</u>

M242.1 Earned Income Exclusions

The following are excluded from earned income.

- (a) Support service payments made directly to the providers of services in the Limited Work Experience Program under the Workforce Investment Act of 1998 (29 U.S.C. §794d) or needs-based payments of \$10 per day made to participants in the program are excluded income.
- (b) The earned income of a child under the age of 22 who is a student regularly attending school. This applies to wages received from regular employment, self-employment, or payments from the Neighborhood Youth Corps, Work Study and similar programs.
- (c) Infrequent or irregular earned income received, not to exceed \$30 per calendar quarter.
- (d) Any in-kind assistance received from others.
- (e) Earned Income Tax Credit payments (both refunds and advance payments).
- (f) The earned income of a working disabled person when performing the second step of the categorically needy eligibility test redetermining net income, set forth in M200.24 (b).
- (g) The earned income of a child under the age of 18.

M242 <u>Income Exclusions</u> (Continued)

M242.2 Unearned Income Exclusions

Unearned income exclusions are limited to the following items.

- (a) Expenses incurred as a condition of receiving the unearned income. For example, guardianship fees may be deducted if having a guardian is a requirement for receiving the income or attorney fees, and court costs may be deducted if they were incurred in order to establish a right to the income.
- (b) Certain Veteran's Administration payments:
 - (i) portion of pension or compensation payment for aid and attendance and housebound allowances, even when the provider is a spouse or a parent;
 - (ii) augmented portion of pensions, compensation or other benefits for a dependent of a veteran or veteran's spouse;
 - (iii) \$20 from educational benefits to the veteran funded by the government;
 - (iv) educational benefits paid as either part of a plan of vocational rehabilitation or by withdrawals from the veteran's own educational fund;
 - (v) clothing allowance; and
 - (vi) payment adjustments for unusual medical expenses
- (c) Ordinary and necessary expenses of rental property and other capital investments except depreciation or depletion of property. This includes but is not limited to interest on debts, state and local taxes. The expenses of managing or maintaining the property, as of the date the expense is paid, are not deductible.
- (d) Alimony and support payments received.
- (e) Infrequent or irregular payments of interest and dividends, up to \$20.00 per month.
- (f) Royalties that represent self-employment earnings from a royalty-related trade or business.
- (g) Medical care and services or social services provided in cash or in-kind, including vocational rehabilitation and payment of medical insurance premiums by a third party.

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M242 Income Exclusions

M242.2 Unearned Income Exclusions (Continued)

- (h) Any public agency's refund of taxes on food or real property.
- (i) Infrequent or irregular income payments that do not exceed \$20.00 in a month.
- (j) Bills paid directly to vendors by a third party.
- (k) Replacement of lost, stolen or destroyed income.
- (1) Weatherization assistance.
- (m) Receipts from the sale, exchange or replacement of a resource.
- (n) Any assistance based on need which is funded wholly by the state, such as General Assistance.
- (o) Public assistance benefits of individuals who are living with an applicant, as well as any income that was used to determine the amount of those benefits
- (p) Any portion of a grant, scholarship or fellowship used to pay tuition, fees or other necessary educational expenses.
- (q) Home produce used for personal consumption.
- (r) Assistance and interest earned on assistance for a catastrophe from the Disaster Relief and Emergency Assistance Act or other comparable assistance provided by the federal, state or local government.
- (s) Irregular and unpredictable voluntary cash contributions or gifts received from friends or relatives.
- (t) Payments for providing foster care for children or adults placed in the individual's home by a public or private non-profit placement agency.
- (u) One-third of child support payments received for a child in the household of the applicant or recipient. Note: the remaining two-thirds of the support payments are considered the unearned income of a child received from an absent parent.
- (v) Income paid for chore, attendant or homemaker services under a government program, such as Title XX personal services payments or the \$90.00 Department of Veterans Affairs (VA) Aid and Attendance payments to veterans in nursing homes.
- (w) Any "in-kind" assistance received from others.

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M242 Income Exclusions

M242.2 <u>Unearned Income Exclusions</u> (Continued)

- (x) Assistance provided in cash or in kind (including food, clothing, or shelter) under a government program that provides medical care or services (including vocational rehabilitation).
- (y) That portion of a benefit intended to cover the financial need of other individuals, such as AABD-EP grants.
- (z) Retroactive payments of federal SSI, the AABD supplement to SSI or Old Age and Survivor and Disability Insurance (OASDI) benefits if the payments were included in determining financial eligibility for Medicaid in the month it was actually owed to the individual.
- (aa) Home energy assistance provided by a private nonprofit organization or a regulated supplier of home energy.
- (bb) State-administered victims' compensation payments.
- (cc) State or local government relocation payments.
- (dd) Payments occasioned by the death of another person to the extent that they are used to pay for the deceased person's last illness and burial, including gifts and inheritances.
- (ee) Payments occasioned by the death of another person to the extent that they are used to pay for the deceased person's last illness and burial, including gifts and inheritances.
- (ff) Earned Income Tax Credit payments (both refunds and advance payments).
- (gg) Cash received as the beneficiary of a life insurance policy minus any expenses incurred, up to a maximum of \$1,500 set aside to pay for the cost of the insured individual's last illness and burial.
- (hh) Up to \$500 per month of social security disability insurance benefits (SSDI) provided to working disabled persons when performing the second step of the categorically needy eligibility test redetermining net income, set forth in M200.24 (b).
- (ii) Dividends paid on life insurance policies, excluding interest.
- (jj) Payments made from a supplemental needs trust made to or for the benefit of an individual.
- (kk) Exclusions based on federal law as set forth in M232.89.

Medicaid Rules

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Vermont Department of Prevention,

M430 Patient Share Payment for Long-Term Care, Including Waiver and Hospice Services

Once the department determines individuals are eligible for long-term care including waiver and hospice services, it computes how much of their income must be paid to the long-term care provider each month for the cost of care (patient share). The department determines the patient share amount at initial eligibility, eligibility redeterminations, and when changes in circumstances occur.

An individual's patient share is determined by computing the maximum patient share and deducting allowable expenses. Sections M431-M431.2 describe how the department determines the maximum patient share. Sections M432-M432.32 describe allowable deductions from the patient share. The actual patient share equals the lesser of either the balance of a patient's income remaining after computing the patient share or the cost of care remaining after the third party payment.

In cases in which allowable deductions exceed the individual's income, the patient share payment is reduced by the deductions, sometimes resulting in no patient share obligation. When monthly income and medical expenses are stable, the patient share amount remains constant. When income or allowable deductions fluctuate, the patient share payment usually varies.

Individuals owe their patient share by the last day of the month in which they receive the income. Payment is made either to the facility in which they resided or the highest paid provider of long-term care waiver services. The department may adjust patient share payments to long-term care providers when a patient transitions from one living arrangement to another, as specified in M433-M433.3.

When monthly income and medical expenses are stable, the patient share payment remains constant. When deductions fluctuate, the patient share payment is likely to vary. When allowable deductions exceed the individual's income, the patient share payment is zero for as many months needed to exhaust the medical expenses against the patient's available income. The month when the remaining medical expense deductions no longer exceed the patient's income, the balance is the patient share payment for that month.

M431 Determining Residence Period for Long-Term Care

The department assesses a patient share obligation in the month of admission to long-term care as long as the individual is expected to remain in long-term care for at least 30 consecutive days. If long-term care is expected to be needed for fewer than 30 consecutive days, the department does not assess any patient share. Instead, the department covers these services through community Medicaid or VHAP, if the individual meets those eligibility rules.

(a) Beginning of long-term care residence period in a general hospital setting

The long-term care residence period in a general hospital setting begins with the first day that the utilization review committee finds acute hospital care is no longer medically necessary and skilled nursing care is medically necessary.

(b) Beginning of long-term care residence period in other long-term care settings

The long-term care residence period in long-term care settings, other than a general hospital, begins with the first day that the utilization review committee finds medical need for long-term care or the date of admission, whatever is later.

(c) Ending of long-term care residence period

A long-term care residence period ends with the earliest of the date of death; the date of discharge from a long-term care living arrangement (see rule M401.2); or the last day medical need for long-term care is established by utilization review committee.

A long-term care residence period is not ended by a leave of absence from the current setting (see rule M930.1). A long-term care residence period also continues despite transfer from either:

- one long-term care setting to another long-term care setting:
- a general hospital setting (where skilled nursing care has been continuously authorized while awaiting transfer) to another long-term care setting; or
- a long-term care setting to a general hospital setting followed by return to the long-term care setting without an intervening residence period in a community living arrangement (see rule 401.1).

M431.1 Determining the Percentage of the Month the Individual was in Long-Term Care

Determine the percentage of the month individuals were in long-term care using the appropriate table below.

All Months Except February

Day of the month admitted to	Percentage of month in	Day of the month admitted to	Percentage of month in	Day of the month admitted to	Percentage of month in
long-term care	long-term care	long-term care	long-term care	long-term care	long-term care
1	100%	11	67%	21	33%
2	97%	12	63%	22	30%
3	93%	13	60%	23	27%
4	90%	14	57%	24	23%
5	87%	15	53%	25	20%
6	83%	16	50%	26	17%
7	80%	17	47%	27	13%
8	77%	18	43%	28	10%
9	73%	19	40%	29	7%
10	70%	20	37%	30-31	3%

February

Day of the month	Percentage of	Day of the month	Percentage of	Day of the month	Percentage of
admitted to	month in	admitted to	month in	admitted to	month in
long-term care	long-term care	long-term care	long-term care	long-term care	long-term care
1	100%	11	64%	21	29%
2	96%	12	61%	22	25%
3	93%	13	57%	23	21%
4	89%	14	54%	24	18%
5	86%	15	50%	25	14%
6	82%	16	46%	26	11%
7	79%	17	43%	27	7%
8	75%	18	39%	28	4%
9	71%	19	36%	29	0%
10	68%	20	32%		

M431.2 Determining the Maximum Patient Share

Multiply the individual's gross income by the applicable percentage of the month that the individual resided in the institution or received waiver or hospice services from the tables at M431.1. This is the individual's maximum patient share in the month of admission.

M432 Deductions from Patient Share

When determining the patient share amount, the department deducts the following from gross income:

- SSI/AABD, AABD only and ANFC benefit payments still being received when the person first enters long-term care;
- SSI/AABD payments intended to be used to maintain the community residence of persons temporarily (not to exceed 3 months) in institutions;
- Austrian Reparation Payments;
- German Reparation Payments;
- Japanese and Aleutian Restitution Payments;
- Payments from the Agent Orange Settlement Funds; and
- Radiation Exposure Compensation.
- VA payments for aid and attendance paid to a veteran residing in a nursing home or to the veteran's surviving spouse residing in a nursing home.

Then the department deducts the following items from the individual's patient share specified in the subsections below in the following order:

- (a) a personal needs allowance or community maintenance allowance (M432.1);
- (b) home upkeep expenses, if applicable (M432.2);
- (c) allocations to community spouse or maintenance needs of family members living in the community, if applicable (M432.3); and
- (d) medical expenses incurred, if applicable (M420-M422).

Unpaid patient share obligations may not be used to reduce a current patient share obligation.

M432.1 Personal Needs Allowance and Community Maintenance Allowance

The department deducts a reasonable amount for clothing and other personal needs of the individual from monthly income. For institutionalized individuals, the department applies a standard personal needs deduction. For individuals receiving waiver or hospice services, the department applies a standard community maintenance deduction. Unlike the institutionalized individual, whose room and board are covered by Medicaid, persons in the waiver and hospice living arrangements have higher allowances to provide a reasonable amount for food, shelter, and clothing to meet their personal needs.

M432 <u>Deductions from Patient Share</u> (Continued)

M432.2 <u>Home Upkeep Deduction</u>

The department deducts expenses from the monthly income of an individuals receiving long-term care and living in a nursing facility or receiving enhanced residential care (ERC) waiver services to help maintain their owned or rented home in the community for three months, renewable for up to an additional three months. It is available for each separate admission to long-term care, as long as the criteria listed below are met. The home upkeep standard deduction equals three-fourths of the SSI/AABD payment level for a single individual living in the community.

- (a) The department grants the deduction when the Medicaid group has income equal to or greater than the standard home upkeep deduction and the Medicaid group has income greater than the personal needs allowance (PNA).
- (b) An individual receiving less income than the standard home upkeep deduction may deduct an amount for home upkeep equal to the difference between the income and the standard home upkeep deduction. This deduction may be applied at any point during the institutionalization as long as all criteria for the deduction are met:
 - (i) no one resides in the long-term care beneficiary's home and receives an allocation as a community spouse or other eligible family member; and
 - (ii) the beneficiary submits a doctor's statement before each three-month deduction period, stating that the beneficiary is expected to be discharged from the institution within six months and to return home immediately after discharge.

If the situation changes during this six-month period, the Medicaid group's eligibility for the home upkeep deduction must be redetermined. The department will deny or end the deduction when:

- the home is sold or rented,
- rented quarters are given up, or
- the individual's health requires the long-term care admission period to last longer than six months.

M432 <u>Deductions from Patient Share</u> (Continued)

M432.3 <u>Allocation to Family Members</u>

The department allows individuals to allocate their income to certain family members as described in the following subsections.

M432.31 Allocation to Community Spouse

The department may deduct a community spouse income allocation for the needs of spouses living in the community (community spouse) from the incomes of individuals receiving long-term care, including waiver and hospice services, (institutionalized spouse). The term community spouse applies to the spouse of an individual receiving long-term care services, even if the community spouse is also receiving waiver or hospice services. When one spouse in a nursing facility and the other is receiving waiver services, the waiver spouse may receive an allocation. When both spouses are receiving waiver services, either may allocate to the other.

Institutionalized spouses may allocate less than the full amount to their community spouse or may allocate nothing. The allocation is reduced by the gross income, if any, of the community spouse and is available only when the countable resources of the community spouse do not exceed the community spouse resource allocation maximum or a higher amount set by a fair hearing or court order. Community spouses, as well as institutionalized spouses, have a right to request a fair hearing.

The standard community spouse income allocation equals 150 percent of the federal poverty level for two. The actual community spouse income allocation equals the standard community spouse allocation plus any amount by which actual shelter expenses exceed the standard allocation, up to the maximum. The maximum community spouse income allocation equals a maximum provided by the federal government each year by November 1.

The department applies the following presumptions to ownership of income when determining the community spouse allocation, unless an institutionalized spouse establishes by a preponderance of the evidence that the ownership interests in income are other than as follows:

- income paid in the name of the spouse is considered available only to the named spouse;
- income paid in the name of both spouses is considered available in equal shares to each;
- income paid in the name of either spouse and any other person is considered available to that spouse is proportion to his or her ownership interest;
- income paid in the name of both spouses and any other person is considered available to each spouse in an amount of one-half of the joint interest.

M432 Deductions from Patient Share

M432.3 Allocation to Family Members (Continued)

M432.32 Allocation to Other Family Members

The department allows a deduction for the following family members, unless the member's countable resources exceed \$12,000:

- any child under age 18; and
- any dependent children, parents, or siblings of either spouse, as specified below.

For the purposes of this subsection, the department considers individuals dependents if they meet each of the following three criteria:

- they have been or will be a member of the household of the beneficiary for at least one year;
- more than one half of their total support is provided by the beneficiary; and
- they have gross annual income below \$2500 or are a child of the beneficiary under age 19 or under age 24 and a full-time student during any five months of the tax year.

When family members live with the community spouse of a person living in a nursing facility, the deduction equals the maintenance income standard reduced by the gross income of each family member and dividing by three. The resulting amount is the maximum allocation that may be made to each family member.

When family members do not live with the community spouse of the person living in a nursing facility, the deduction equals the applicable protected income level for the number of family members living in the same household as the family member, reduced by the gross income, if any, of the family members in the household.

The department may require the family members described above to apply for SSI, AABD or Reach Up, as long as this would not disadvantage them financially.

M433 Determining which Provider Receives Patient Share Payment

Individuals receiving long-term care sometimes move from one facility to another, such as from one nursing home to another or from a nursing home to a hospital and back to the same or another nursing home. Patient share payments must be paid toward the cost of the individual's care from income received by the individual during each month of a continuous period of living in long-term care.

As a general rule, the provider giving long-term care services to the individual on the last day of the preceding month sends the individual a bill for the patient's share of the cost for that month. Payment is made to the nursing facility if the individual was receiving long-term care in a nursing facility on the last day of the preceding month. Payment is made to the highest paid provider of waiver services if the individual is active on a waiver program on the last day of the preceding month. Exceptions to this rule are specified in the subsections below.

If payment of a patient share results in a credit to the provider then the provider sends the excess to the Office of Vermont Health Access of the Department of Prevention, Assistance, Transition, and Health Access.

M433.1 Payment of Patient Share when Long-Term Care Recipient Enters Hospital

Long-term care Medicaid recipients who are hospitalized remain long-term care recipients and their patient share amount is not redetermined. The department allocates payment of the patient share to the providers as follows:

- (a) For acute care: the patient share is paid directly to the Office of Vermont Health Access of the Department of Prevention, Assistance, Transition, and Health Access when the recipient is hospitalized and receiving acute hospital care on the last day of the month preceding the month in which income is received. Failure to pay patient share may result in closure of Medicaid eligibility.
- (b) For level I or II nursing care: the patient share is paid to the hospital when the recipient is hospitalized and receiving level I or level II nursing facility care in the hospital on the last day of the month preceding the month in which income is received.

M433.2 Payment of Patient Share when Long-Term Care Recipient of Waiver Services Enters a Nursing Facility

- (a) For respite services: the department does not adjust patient share payment when a long-term care recipient of waiver services enters a nursing facility for respite services. The patient share is paid to the highest paid provider of waiver services, even if the individual is in a nursing home on the last day of the month and receiving respite services.
- (b) For other services: The department adjusts the patient share amount when a long-term care recipient of waiver services enters a nursing facility for services other than respite and has been in the nursing facility for a full calendar month. The patient share is paid to the nursing facility since the individual was receiving long-term care in a nursing facility on the last day of the month.

M433.3 Payment of Patient Share when Long-Term Care Recipient is Discharged from a Nursing Facility and to Waiver Services

The department adjusts the patient share amount when individuals are in a nursing facility for more than one full calendar month and discharged to waiver services. After the patient share payment is redetermined using the community maintenance allowance, the first month's patient share is paid to the nursing facility because the individual resided in the facility on the last day of the previous month. Thereafter it is paid to the highest paid provider of waiver services.

M433.4 Payment of Patient Share for the Month when Long-Term Care Recipient is Discharged from Long-Term Care

The department excludes all income long-term care recipients receive during the month of discharge from long-term care and any month after discharge when long-term care Medicaid recipients leave a long-term care living arrangement (M401.2). Long-term care providers must refund patient share payments made by long-term care Medicaid recipients when they pay their patient share from income received in the month of their discharge.

M433.5 Payment of Patient Share for the Month when Long-Term Care Recipient is No Longer Eligible for Medicaid Coverage of Long-Term Care

Long-term care Medicaid recipients become fully responsible for the total cost of any care they receive after the effective date of the decision when they remain institutionalized after a medical review team decision that they no longer need skilled nursing or intermediate care, or they become ineligible for other reasons. Recipients usually must pay in advance for such care as a private patient. They incur no patient share obligation for the calendar month that the review decision takes effect.

The long-term care providers must credit payment toward the cost of private care furnished after the effective date of the decision to end Medicaid long-term care coverage when long-term care Medicaid recipients have already paid their patient share to the institution during the calendar month the review decision takes effect.

M433.6 Payment of Patient Share in the Month of Death

The department counts income received during the calendar month of the death of a long-term care Medicaid recipient and applies it to the cost of their care received during the prior month. For example, if a long-term care Medicaid recipient dies on June 26, the patient share payment from income received during June is due for care provided in May. If a long-term care Medicaid recipient dies on July l, the patient share payment from any income received during July is due for care provided in June.

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	M440.4	Dete	rmination of the Penalty Period for Di	sallowed Transfers
	M44	40.41	Penalty Date	
	M44	40.42	Penalty Period	
	M44	40.43	Assignment of Penalty Periods whe	en both Spouses Request Long-
			Term Care Coverage	1 1
	M44	40.44	Undue Hardship	

M440 Transfer of Income or Resources by Individuals Requesting Long-Term Care Coverage

The department shall determine whether transfers of income or resources made by applicants and recipients requesting Medicaid coverage of long-term care expenses, or by any member of their financial responsibility group, are allowable transfers under the rules set forth in this section. If the department determines that such transfers are not allowable, the person requesting long-term care coverage shall not be eligible for such coverage until a penalty period has expired. The beginning and duration of the penalty period shall be based upon the date and value of the disallowed transfers.

The department shall make this determination concerning transfers occurring before the individual requests coverage of long-term care services, including waiver and hospice services, as part of its determination of initial eligibility for such coverage. Once the department has determined that a transfer is disallowed and has established a penalty period, that transfer is not reconsidered unless the department obtains new information about the transfer. If the department discovers that the individual has made additional transfers after the initial determination, the department shall also determine whether these are allowable, whether the dates of transfer are before or after the initial determination, and establish penalty periods as required. After the month in which an individual is determined eligible for long-term care Medicaid, no resources of the community spouse shall be determined available to the institutionalized spouse.

Section M440.1 sets forth a definition of transfers.

Sections M440.2 and M440.3 specify the criteria for allowable transfers, to which no penalty period applies, effective for all initial long-term care Medicaid eligibility determinations and redeterminations. No other transfers are allowable.

M440.1 Definition of Transfer

A transfer of income or resources, for the purposes of this section, means any action taken by a member of the financial responsibility group (see rules M200.1(d); and M221) or by any other person with lawful access to the income or resources (see rule M440.35) that disposes of the member's income or resources. The date of the transfer is the date this action was taken. It also applies to certain income and resources to which the member is entitled but does not have access because of an action taken by:

- a member of the financial responsibility group entitled to the income or resources;
- a person, including a court or administrative body, with legal authority to act in place of or on behalf of the member or the member's spouse, entitled to the income or resources; or
- a person, including a court or administrative body, acting at the direction or upon the request of the member or the member's spouse, entitled to the income or resources.

M440 <u>Transfer of Income or Resources by Individuals Requesting Long-Term Care Coverage</u> (Continued)

M440.2 Allowable Transfers for Fair Market Value

No penalty period is applied to income or resources transferred for fair market value.

Fair market value means an amount equal to the price of an item on the open market in the individual's locality at the time of a transfer, or contract for sale, if earlier. The department determines whether an individual received fair market value for a transfer of income or resources by determining the difference, if any, between the fair market value of any asset reduced by any applicable deductions at the time of the transfer and the amount received for the asset.

Any of the following deductions may be used to reduce fair market value:

- (a) the amount of any legally enforceable liens or debts against the transferred income or resource at the time of transfer that reduced the transferor's equity in the income or resource;
- (b) the reasonable and necessary costs of making the sale or transfer;
- (c) the value of income or resources received in exchange for the transferred income or resources;
- (d) the value of income or resources returned to the individual; and
- (e) the following verified payments or in-kind support given to or on behalf of the individual as compensation for receipt of the income or resources by the person who received the income or resources:
 - personal services;
 - payments for medical care;
 - funeral expenses of the individual's deceased spouse;
 - taxes, mortgage payments, property insurance, or normal repairs on the transferred property; or
 - support and maintenance (e.g., food, clothing, incidentals, fuel and utilities) provided in the individual's own home or in the home of the person who received the income or resource.

M440 <u>Transfer of Income or Resources by Individuals Requesting Long-Term Care Coverage</u> (Continued)

M440.21 Scheduled Receipt of Fair Market Value After the Date of Transfer

If the value of a transferred resource other than an annuity is scheduled for receipt after the date of transfer, the department considers it a transfer for fair market value if the individual can expect to receive the full fair market value of the resource within his or her expected lifetime, as determined by the department.

The department considers the purchase of an annuity a transfer for fair market value if the annuity:

- is actuarially sound;
- provides for payments at equal intervals and in equal amounts;
- returns at least the transferred amount to the individual within his or her expected lifetime, as determined by the department; and
- has been established for the sole benefit of a member of the Medicaid group.

The department uses an actuarial table set forth in the Medicaid procedures manual to determine life expectancy.

M440 <u>Transfer of Income or Resources by Individuals Requesting Long-Term Care Coverage</u> (Continued)

M440.3 Allowable Transfers for Less than Fair Market Value

The department does not impose a penalty period for transfers made by members of the financial responsibility group for less than fair market value that meet one or more of the following criteria.

- (a) The income or resource transferred was not in a trust, and the date of the transfer was more than 36 calendar months prior to the first month in which the applicant or recipient both requests Medicaid coverage of long-term care expenses and meets all other requirements for Medicaid eligibility.
- (b) The transferred income or resources have been returned to the individual or otherwise remain available to the individual or another member of the financial responsibility group.
- (c) The action that constituted the transfer was the removal of a member's name from a joint account in a financial institution, and the member has demonstrated, to the department's satisfaction, that the funds in the account accumulated from the income and resources of another owner who is not a member of the financial responsibility group.
- (d) The member has documented to the department's satisfaction that the transfer was made exclusively for a purpose other than qualifying for Medicaid.

There is a rebuttable presumption that the resources were transferred for the purpose of establishing or maintaining eligibility for long-term care. The presumption is rebutted only if the individual provides convincing evidence that the resources were transferred exclusively for a purpose other than to become or remain eligible for long-term care. A signed statement by the individual is not, by itself, convincing evidence.

Examples of convincing evidence are documents showing that:

- the transfer was not within the individual's control (e.g., was ordered by a court);
- the individual could not have anticipated long-term care eligibility on the date of transfer (e.g., the individual became disabled due to a traumatic accident after the date of transfer); or
- a diagnosis of a previously undetected disabling condition leading to long-term care eligibility was made after the date of transfer.
- (e) The transfer meets the criteria specified in M440.31-440.32 for transfers involving trusts, transfers of homes, and transfers for the benefit of certain family members.
- (f) The individual intended to dispose of the income or resources either at fair market value, or for other valuable consideration.
- (g) The member transferred excluded income or resources, other than the home.

M440 <u>Transfer of Income or Resources by Individuals Requesting Long-Term Care Coverage</u> (Continued)

M440.31 Allowable Transfers Involving Trusts for Less than Fair Market Value

The department does not impose a penalty period for transfers involving trusts that meet one or more of the following criteria.

- (a) The income or resources were transferred to a trust, and the date of the transfer was more than 60 calendar months prior to the first month in which the applicant or recipient both requests Medicaid coverage of long-term care expenses and meets all other requirements for Medicaid eligibility.
- (b) The income or resources were transferred to an irrevocable trust that does not under any circumstances allow disbursements to or for the benefit of the individual, and the date of the transfer was more than 36 calendar months prior to the first month in which the applicant or recipient both requests Medicaid coverage of long-term care expenses and meets all other requirements for Medicaid eligibility.
- (c) The action that constituted the transfer was the establishment of a trust solely for the benefit of a person under age 65 who is blind or permanently and totally disabled.
- (d) The action that constituted the transfer was the establishment of a special or supplemental needs trust or pooled trust, specified at M232.52(e).
- (e) The action that constituted the transfer was the establishment of a revocable trust. Payments to anyone other than the individual must be considered a transfer for less than fair market value, however.

M440 <u>Transfer of Income or Resources by Individuals Requesting Long-Term Care Coverage</u> (Continued)

M440.32 Allowable Transfers of Homes to Family Members for Less than Fair Market Value

The department does not impose a penalty period for transfer of a home that meets the definition at M232.11, provided that title was transferred by a member of the financial responsibility group to one or more of the following persons:

- (a) the member's spouse;
- (b) the member's child who was under age 21 on the date of the transfer;
- (c) a son or daughter who is blind or permanently and totally disabled, regardless of age;
- (d) the brother or sister of the member requesting coverage of long-term care expenses, when the brother or sister had an equity interest in the home on the date of the transfer and was residing in the home continuously for at least one year immediately prior to the date the person began to receive long-term care services, including waiver and hospice services; or
- (e) the son or daughter of the member requesting coverage of long-term care expenses, provided that the son or daughter was residing in the home continuously for at least two years immediately prior to the date the parent began to receive long-term care services, including waiver and hospice services and provided care to the parent during part or all of this period that allowed the parent to postpone receipt of long-term care services, including waiver and hospice services.

M440.33 Other Allowable Transfers to Family Members for Less than Fair Market Value

The department does not impose a penalty period for transfers that meet any of the following criteria.

- (a) The transfer was for the sole benefit of the individual requesting coverage for long-term care services, including waiver and hospice services.
- (b) The income or resource was transferred by an institutionalized spouse to the community spouse before the initial determination of the institutionalized spouse's eligibility for long-term care coverage. This also applies to a transfer made to a third party for the sole benefit of the community spouse.
- (c) The income or resource was transferred to a trust for the sole benefit of a son or daughter who is blind or permanently and totally disabled, regardless of age.

M440 <u>Transfer of Income or Resources by Individuals Requesting Long-Term Care Coverage</u>

M440.34 Transfers involving Annuities

(a) Allowable Transfers

The department does not impose a penalty when income or resources were used to purchase an annuity more than 36 months ago or meet the criteria for an excluded resource in M232.4.

(b) Impermissible Transfers

When the beneficiary has a spouse, an annuity will not be considered a permissible transfer if some one other than individual requesting long-term care Medicaid or his or her spouse, is a named beneficiary, even when both spouses die before the payout period ends.

Action by applicants or their spouses to abandon or transfer ownership of an annuity shall be treated as a transfer of resources.

When annuities are considered an impermissible transfer, the total value of the transfer is the cash value. The cash value equals the amount of money used to establish the annuity and any additional amounts used to fund the annuity, plus any earnings and minus any early withdrawals and surrender fees, unless the individual can furnish evidence from a reliable source showing that the annuity is worth a lesser amount. Reliable sources include banks, other financial institutions, insurance companies, and brokers, as well as any other the department considers, in its discretion, to be reliable.

Vermont Department of Prevention, Assistance, Transition, and Health Access Medicaid Rules

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M440 Transfer of Income or Resources by Individuals Requesting Long-Term Care Coverage

M440.35 Transfers involving Jointly Held Income or Resources

(a) Transfers after January 1, 1994

For joint ownerships established after January 1, 1994, the portion of jointly held assets subject to penalty is evaluated by the department based on the specific circumstances of the situation. The department presumes individuals own the value of the resource using rules in M233 and its subsections. Individuals may rebut the presumption of ownership by establishing to the department's satisfaction that the amount withdrawn was, in fact, the sole property of and contributed to the account by the other person, and thus did not belong to the individual. In the case of accounts in financial institutions (rule M231.21), for example, the portion subject to transfer penalty is the amount withdrawn by a joint owner. In the case of life estates, for example, individuals may transfer their home and retain a life estate without being subject to penalty if they have retained the right to sell the property. In this situation their ownership interest has not been reduced or eliminated.

(b) Transfers before January 1, 1994

For joint ownerships established before January 1, 1994, the date of the transfer is the date the other person became a joint owner. The value of the transfer equals the amount that the resource available to the individual or the individual's spouse was reduced in value.

M440 <u>Transfer of Income or Resources by Individuals Requesting Long-Term Care Coverage</u> (Continued)

M440.4 Determination of the Penalty Period for Disallowed Transfers

If a transfer is disallowed, the department imposes a penalty period of restricted Medicaid coverage to an otherwise eligible individual. During this period, no Medicaid payments are made for long-term care services, including waiver and hospice services. Medicaid payments are made for all other covered services provided to the recipient during the period of restricted coverage.

M440.41 Penalty Date

The penalty date is the beginning date of each penalty period imposed for a disallowed transfer. The period of restricted coverage begins the first day of the month the asset was transferred if that does not occur in any other period of restricted coverage.

Penalty periods for transfers occurring in different months run consecutively rather than concurrently, in the order in which the transfers occurred. If, after establishing a penalty period for disallowed transfers, the department determines that additional disallowed transfers were made in a subsequent month but before the end of the first penalty period, the department shall designate the first day following the end of the first penalty period as the penalty date for the subsequent penalty period.

M440.42 Penalty Period

For transfers that occurred before July 1, 2002, the number of months in a penalty period shall be equal to the total value of all disallowed transfers made during a given calendar month divided by the average monthly cost to a private patient of nursing facility services as of the date of application. When a fraction of a month results, the months are rounded down to the nearest whole number.

For transfers that occurred on or after July 1, 2002, the number of days in a penalty period shall be equal to the total value of all disallowed transfers made during a given calendar month divided by the average daily cost to a private patient of nursing facility services in the state as of the date of application or the date of discovery, if the department discovered additional disallowed transfers after the initial determination of eligibility for long-term care coverage.

Penalty periods for transfers in different calendar months shall be consecutive and established in the order in which the disallowed transfers occurred.

A penalty period runs continuously from the first date of the penalty period, even if the individual stops receiving long-term care services, including waiver and hospice services.

M440 <u>Transfer of Income or Resources by Individuals Requesting Long-Term Care Coverage</u> (Continued)

M440.43 Assignment of Penalty Periods when both Spouses Request Long-Term Care Coverage

The department applies the following rules to the assignment of penalty periods when both members of a couple are requesting or receiving Medicaid coverage of long-term care services, including waiver and hospice services.

- (a) For spouses determined otherwise eligible for Medicaid payment of long-term care services at the same time, the department divides the value of the disallowed transfer by two to determine the number of days of restricted coverage for each member of the couple.
- (b) If the penalty period established for one member of the couple has not yet expired when the other member of the couple requests and is determined otherwise eligible for Medicaid payment of long-term care services, the number of days remaining in the penalty period shall be divided by two to determine the number of days of restricted coverage for each member of the couple.
- (c) When the member of the couple for whom a penalty period has been established dies, the days remaining in that member's penalty period shall not be reassigned to the member's spouse, if the spouse requests and is determined otherwise eligible for Medicaid payment of long-term care services.
- (d) When the department establishes a penalty period for a disallowed transfer by the second member of the couple to request and be determined otherwise eligible for Medicaid payment of long-term care services, the department assigns that penalty period to the spouse who made the transfer, provided that it was made after the determination of disallowed transfers for the first spouse.

M440 <u>Transfer of Income or Resources by Individuals Requesting Long-Term Care Coverage</u> (Continued)

M440.44 Undue Hardship

The department does not establish a penalty period when it determines that restricted coverage would work an undue hardship. Undue hardship exists if one or more of the following conditions are met:

- (a) Funds can be made available for medical care only if assets such as a family farm or other family business are sold, and the assets are the sole source of income for the individual's spouse, parents, children or siblings.
- (b) Sale of the of the income producing assets would result in the immediate family qualifying for Supplemental Security Income, Reach Up, Aid for the Aged, Blind or Disabled, General Assistance, Food Stamps, or another public assistance program requiring a comparable showing of financial need.
- (c) A power of attorney (POA) or guardian transferred the asset, and the court has ruled the POA or guardian was not acting in the best interest of the individual when the transfer was made, or the transfer forms the basis for a referral to the Department of Aging and Disabilities, Division of Adult Protective Services, for investigation of abuse or neglect.
- (d) An individual presents other circumstances with similar impact, in the department's judgment, to those enumerated above.

DRAFT Worksheet: Information is self-reported by the individual or their legal representative.

A. Monthly Gross Income (from ILA)

	Individual	Spouse
Social Security	\$	\$
SSI	\$	\$
Retirement/Pension	\$	\$
Interest	\$	\$
VA Benefits	\$	\$
Wages/Salaries/Earnings	\$	\$
Other (i.e. rental income)	\$	\$
Subtotal:	\$	\$
A. Total Monthly Gross Income:	\$	

B. *Asset Adjustment: (Include only "liquid" assets that are easily convertible into cash.)

	Individual	Spouse
Cash:	\$	\$
Savings:	\$	\$
Checking:	\$	\$
CD's:	\$	\$
Money Market:	\$	\$
Stocks/Bonds:	\$	\$
Trusts:	\$	\$
Other:	\$	\$
Subtotal:	\$	\$
Total Combined Assets:	\$	
subtract:	- 10	,000
divide:	/1.	2
B. Asset Adjustment:	\$	

<u>C. Monthly Medical Expenses</u> (Divide one-time bills by 12.)

	Individual	Spouse
Prescriptions:	\$	\$
Over-the-counter medications:	\$	\$
Physician Bills:	\$	\$
Hospital Bills:	\$	\$
Health Ins Premiums (Medicare/BCBS, etc):	\$	\$
Therapy (OT/PT/ST):	\$	\$
Medical Equipment and Supplies:	\$	\$
Other (explain):	\$	\$
Subtotal:	\$	\$
C. Total Monthly Medical Expenses:	\$	

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A. Total Monthly Gross Income (above): \$	
	plus (+)
B. Asset Adjustment (above): \$	-
	minus (-)
C. Monthly Medical Expenses (above): \$	
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D. Adjusted Monthly Income	\$
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Coverage Group	Group Description	Income Standard	Resource Standard	Income Methodology	Resource Methodology
		COMMUNITY M	IEDICAID		
Mandatory	v Categorically Needy				
1.	SSI Recipient (individuals receiving SSI cash benefits, AABD state supplemental benefits, or both) §1902(a)(10)(A)(i)(II) Vermont Rule M200.	n/a	n/a	receive SSI or AABD or both	receive SSI or AABD or both
2.	SSI-Eligible (Disabled individuals whose earnings are too high to receive SSI cash benefit) §1902(a)(10)(A)(i)(II); §1905(q); §1619(b) Vermont Rule M200	See endnote.i	See endnote ii	See endnote. iii	See endnote. iv
3.	Children no longer eligible for SSI (because of the change in the definition of disability made under PRWORA) §1902(a)(10)(A)(i)(II) Vermont Rule M200.25(a)	See endnote i.	See endnote ii.	See endnote iii.	See endnote iv.
4.	Disabled widows/widowers (closed group; no new applications after July 1, 1988) §1634(b); §1935 Vermont Rule M200.25(b)(i)	See endnote i.	See endnote ii.	See endnote iii.	See endnote iv.
5.	Early widows/widowers §1634(d) Vermont Rule M200.25(b)(ii)	See endnote i.	See endnote ii.	See endnote iii.	See endnote iv.
6.	Disabled adult children §1634(c); §1935 Vermont Rule M200.25(c)	See endnote i.	See endnote ii.	See endnote iii.	See endnote iv.
7.	Individuals determined eligible under the Pickle Amendment §1935(a)(5)(E) Vermont Rule M200.25(d)	See endnote i.	See endnote ii.	See endnote iii and apply "Pickle" methodology.	See endnote iv.

Coverage Group	Group Description	Income Standard	Resource Standard	Income Methodology	Resource Methodology
8.	An essential spouse or other individual who was eligible for Medicaid in December 1973 42 C.F.R. §435.131 Vermont Rule M200.25(e)	See endnote i.	See endnote ii.	See endnotes iii and ^v	See endnotes iv and v.
9.	Individuals who were entitled to Social Security retirement or disability in August 1972 (or would have been if they had applied or were not in a medical institution) § federal citation (unknown) Vermont Rule M200.25(f)	See endnote i.	See endnote ii.	See endnote iii and disregard 20% COLA increase that occurred in September 1972.	See endnote iv.
10.	Qualified Medicare beneficiaries (QMB) §1902(a)(10)(E)(i); §1902(p)(1) Vermont Rule M200.41	100% FPL \$776 month for 1 \$1,041 month for 2	\$4,000 for 1; \$6,000 for 2	See endnote iii.	See endnote iv.
11.	Qualified disabled and working individuals (QDWI) §1902(a)(10)(E)(ii); §1905(s) Vermont Rule M200.42	200% FPL \$1,552 month for 1 \$2,082 month for 2	\$4,000 for 1; \$6,000 for 2	See endnote iii.	See endnote iv.
12.	Specified low-income Medicare beneficiaries (SLMB) §1902(a)(10)(E)(iii) Vermont Rule M200.43	120% FPL \$931 month for 1 \$1,249 month for 2	\$4,000 for 1; \$6,000 for 2	See endnote iii.	See endnote iv.
13.	Qualified individuals (QI-1) §1902(a)(10)(E)(iv)(I) Vermont Rule M200.44	135% FPL \$1,048 month for 1 \$1,406 month for 2	\$4,000 for 1; \$6,000 for 2	See endnote iii.	See endnote iv.

Coverage Group	Group Description	Income Standard	Resource Standard	Income Methodology	Resource Methodology
Optional C	Categorically Needy Groups				
14.	SSI-Eligible (individuals who meet the income and resource requirements of the SSI cash assistance program) 1902(a)(10)(A)(ii)(I)	See endnote i.	See endnote ii.	See endnote iii.	See endnote iv.
15.	Working people with disabilities (BBA working disabled group) §1901(a)(10)(A)(ii)(XIII) Vermont Rule M200.24(b)	See endnote i.	See endnote ii.	See endnote iii and Step 1-determine net family income ≤ 250% FPL; Step 2- disregard all earned income ≤ \$500 of SSDI	See endnote iv.
16.	Breast or cervical cancer (under CDC program) §1902(a)(10)(A)(ii)(XVIII) Vermont Rule M200.24(a)	Meets CDC (Ladies First) income standard	See endnote ii.	See endnote iii and must be ineligible for any other Medicaid coverage group.	See endnote iv.
Medically I	Needy Group				
17.	Medically Needy §1902(a)(10)(C) Vermont Rule M200.3	See endnote 1.	See endnote ii.	See endnote iii and allow spenddown of excess income.	See endnote iv and allow spenddown of excess resources.
		LONG-TERM CARE MEI	DICAID		
Mandatory	Categorically Needy Group				
18.	Individuals living in medical institutions (who would be eligible for SSI or state supplemental payment if they were not in an institution) §1902(a)(10)(A)(ii)(IV) Vermont Rule M200.23(a)	See endnote ^{vi} .	See endnote ^{vii}	See endnotes 3 and viii.	See endnotes 4 and ^{ix} .
Optional Categorically Needy Groups					
19.	Home-and community based waiver services (who would be eligible for Medicaid if they were in a medical institution) §1902(a)(10)(A)(ii)(VI) Vermont Rule M200.23(b)	See endnote vi. Individuals also qualify if they meet requirements for coverage groups numbered in this document as 1, 14, 15, or 22.	See endnote vii.	See endnotes iii and viii.	See endnotes iv and ix.

Coverage Group	Group Description	Income Standard	Resource Standard	Income Methodology	Resource Methodology
20.	Hospice care (terminally ill, would be eligible if they were in a medical institution, and receive hospice care) §1902(a)(10)(A)(ii)(VII) Vermont Rule M200.23(c)	See endnote vi.	See endnote vii.	See endnotes viii and ix.	See endnote iv and ix.
21.	Disabled Child in Home Care (Katie Beckett) §1902(e)(3) Vermont Rule M200.23(d)	See endnote vi.	See endnote vii.	See endnote iii and exclude parents' income. Child is a group of 1.	See endnote vi and exclude parents' resources. Child is a group of 1.
Medically Needy Group					
22.	Medically Needy §1902(a)(10)(A)(ii)(V) Vermont Rule M200.3	See endnote vi.	See endnote vii.	May spenddown excess income to become eligible for institutional or waiver services.	See endnote iv and ix.

Endnotes

¹ Vermont's income standard for most SSI-related Medicaid groups is the PIL or the SSI-AABD payment standard, whichever is higher. The medically needy income level, known in Vermont as the "protected income level" (PIL), varies depending on whether the individual seeking coverage lives in Chittenden County (urban) or outside Chittenden County (rural). The Currently, the PIL is higher for groups of one, and the SSI-AABD payment standard is higher for groups of two, as follows:

Applicable Monthly Income Standard	Chittenden County	Outside Chittenden County
Protected Income Level (PIL or MNIL) for groups of one person	\$850	\$783
SSI-AABD Payment Standard for groups of two people	\$944.88	\$944.88

ii Vermont SSI-related resource standards are: \$2,000 for groups of 1; \$3,000 for groups of 2; and + \$150 each additional person.

- a. Deduct the first \$20 of unearned income per month.
- b. Deduct \$65 and half the remainder of earned income.
- c. Exclude infrequent or irregular voluntary cash contributions or gifts.
- d. Average lump sum receipts of earnings (such as sale of crops or livestock) over a six month period.
- e. Add the countable income of an ineligible spouse to the countable income of the eligible individual and compare it, after deductions to the Medically Needy Income Standard for two, or the SSI-AABD payment standard for two, whichever is higher.

iv Vermont's SSI-related resource methodologies include the following:

- a. Resources of couple, where one member has been admitted to the same long-term care facility are combined for 6 months, if this is to their advantage.
- b. Resources may be spent down to the applicable resource maximum if used for medically necessary expenses.
- c. Real property is excluded if the income it produces is significant to meet living expenses and consistent with fair market value.
- d. Savings from excluded income are excluded.
- e. Vermont does not use the first moment of the first day of the month in counting resources. If the individual is under resources at any time during the month, Medicaid is granted for the entire month if all eligibility criteria are met.

iii Vermont SSI-related income methodologies include the following:

- f. Nonexempt real property which is up for sale is excluded as long as owners verify that they are making reasonable efforts to sell it.
- g. No limit is placed on the value of household goods and personal effects.
- h. Automobiles are excluded.
- i. No limit is placed on the equity value of property used to produce goods for home consumption.
- j. Life estates in real property are excluded when the owner does not retain the power to sell the real property.
- k. Separately identifiable burial funds designated for burial expenses through the title to the fund or by a sworn statement provided to the department are excluded in the amount of \$10,000 per person.
- 1. Annuities are exempt if created more than 36 months before application.
- m. Savings from excluded income are excluded for individuals working with disabilities.
- In addition to the methodology in endnotes 3 and 4, Vermont also applies these rules for this coverage group of individuals who were eligible for Medicaid in December 1973 and meet at least one of the following criteria:
 - an institutionalized individual who has been eligible for Medicaid each consecutive month after December 1973;
 - a blind or disabled individual who meets all current requirements for Medicaid eligibility except blindness or disability and has been eligible for Medicaid each consecutive month after December 1973; or
 - an essential spouse whose needs have been included in computing the SSI or SSI/AABD payment to an aged, blind, or disabled individual living with the essential spouse since December 1973 and both have continuously received AABD.
- vi Vermont long-term care Medicaid's monthly institutional income standard is \$1,656 for individual or \$3,312 for a couple.
- vii Vermont long-term care Medicaid's monthly institutional resource standard is \$2,000.
- viii In addition to methodology noted above in endnote 3, Vermont 's institutional income rules permit deductions for personal, spousal and family monthly needs allowances in the following amounts:

Needs type	Institutional Methodology	Waiver Methodology
Home upkeep	\$462	n/a
Personal	\$47.66	\$850
Spousal maintenance	\$1,515 minimum; \$2,319 maximum	\$1,515 minimum; \$2,319 maximum
Family members	\$505	\$505

ix In addition to methodology noted above, perform resource assessment and allocation for married individuals and allow the maximum spousal allocation of \$92,760 and evaluate transfers of resources.